Integrated Health Project in Burundi (IHPB)

Contract Number: AID-623-C-14-00001

Year 2 Report

December 23, 2014 – September 30, 2015

Submitted by: FHI 360 and partners

Submission date: October 30, 2015

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Table of Contents

Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ABUBEF	*Association Burundaise pour le Bien Etre Familial*
ACTs	Artemisinin-based Combination Therapy
ADBC	*Agent Distributeur à Base Communautaire* (Community Based Distributor of Contraceptives)
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ANSS	*Association Nationale de Soutien aux Séropositifs et aux Sidéens*
ART	Anti-Retroviral Therapy
ARV	Antiretroviral
BCC	Behavior Change Communication
BDS	*Bureau du District Sanitaire* (District Health Bureau)
BEmONC	Basic Emergency Obstetric and Newborn Care
BMCHP	Burundi Maternal and Child Health Project
BPS	*Bureau Provincial de la Santé* (Provincial Health Bureau)
BRAVI	Burundians Responding Against Violence and Inequality
BTC	Belgian Technical Cooperation
CAM	*Carte d'Assistance Médicale* (Health Assistance Card)
CBD	Community Based Distribution
CBO	Community-Based Organization
C-Change	Communication for Change
CCM	Community Case Management
CCT	Community Conversation Toolkit
CD4	Cluster of Differentiation #4
CFR/OMB	Code of Federal Regulations/Office of Management and Budget
CHW	Community Health Worker
CLIN	Cost Line Item Number
COP	Chief of Party
COP	Country Operational Plan
COPED	*Conseil Pour l'Education et le Développement*
COSA	*Comité de Santé*
CPSD	*Cadre de Concertation pour la Santé et le Développement*
CPVV	*Comité Provincial de Vérification et de Validation*
CS	Capacity Strengthening
CSM	Community Services Mapping
CSO	Civil Society Organization
CTN	*Cellule Technique Nationale*
CT FBP	*Cellule technique du Financement Basé sur la Performance*
DATIM	Data for Accountability, Transparency and Impact
DBS	Dried blood Spot testing
DCOP	Deputy Chief of Party
DHE	District Health Educator
DHIS	District Health Information System
DHS	Demographic and Health Survey

DHT	District Health Team
DPE	*Direction Provinciale de l'Enseignement*
DPSHA	*Département de Promotion de la Santé, Hygiène et Assainissement*
DQA	Data Quality Assurance
EC	Emergency Contraception
EID	Early Infant Diagnostic
EONC	Emergency Obstetric and Neonatal Care
ENA	Emergency Nutrition Assessment
FAB	Formative Analysis and Baseline Assessment
FGD	Focus Group Discussion
FHI 360	Family Health International
FFP	Flexible Family Planning Project
FP	Family Planning
FQA	Facility Qualitative Assessment
FSW	Female Sex Worker
FTO	Field Technical Officer
GBV	Gender Based Violence
GoB	Government of Burundi
HBC	Home-Based Care
HC	Health Center
HD	Health District
HH	Household
HIV	Human Immunodeficiency Virus
HPT	Health Promotion Technician
HIS	Heath Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
HO	Home Office
ICASA	International Conference on HIV/AIDS and STIs in Africa
iCCM	Integrated Community Case Management
IDI	In-Depth Interview
IEC	Information, Education and Communication
IHPB	Integrated Health Project in Burundi
INGO	International Non-Governmental Organizations
IP	Implementing Partner
IIP	Institutional Improvement Plan
IKG	in Kind Grant
IMC	Integrated Management of Childhood Illness
IPTp	Intermittent Preventive Treatment of malaria during Pregnancy
IPC	Interpersonal Communication
IRB	Institutional Review Board
ISTEEBU	*Institut de Statistiques et d'Etudes Economiques du Burundi*
ITN	Insecticide-Treated Net
IYCF	Infant Young Child Feeding

Kfw	Kreditanstalt für Wiederaufbau (Établissement de crédit pour la reconstruction) Allemand (German Development Bank)
KII	Key Informant Interview
LMIS	Logistics Management Information System
LOE	Level of Effort
LOP	Life of Project
LPT	Local Partner Transition
M&E	Monitoring and Evaluation
MESAT	M&E System Assessment
MARPs	Most at Risk Populations
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MOP	Malaria Operational Plan
MoU	Memorandum of Understanding
MPHFA	Ministry of Public Health and the Fight against AIDS
MSM	Men having Sex with Men
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
NHIS	National Health Information System
NPAC	National Program for AIDS/STIs Control
NMCP	National Malaria Control Program
NGO	Non-Governmental Organization
NUPAS	Non- US Organization Pre-Award Survey
OIRE	Office of International Research Ethics
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PCR	Polymerase Chain Reaction
PDSA	Plan-Do-Study-Act
PECADOM	*Prise en Charge à domicile* (Community Case Management)
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PHSC	Protection of Human Subjects Committee
PITC	Provider Initiated Testing and Counseling
PLHIV	People Living with HIV
PMEP	Performance Monitoring & Evaluation Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNILP	*Programme National Intégré de Lutte contre le Paludisme*
PNLS	*Programme National de Lutte contre le SIDA*
PNSR	*Programme National de Santé de la Reproduction*
PPP	Public-Private Partnership
PRONIANUT	National Food and Nutrition Program
QA/QI	Quality Assurance/Quality Improvement
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality Improvement Team
RBP+	*Réseau Burundais des Personnes vivant avec le VIH*
RDTs	Rapid Diagnostic Tests

RH	Reproductive Health
RPDQA	Routine Participatory Data Quality Assessment
ROADS II	Roads to a Healthy Future
SAPR	Semi Annual Progress Report
SARA	Services Availability and Readiness Assessment
SDPs	Service Delivery Points
SBC	Strategic Behavior Change
SBCC	Social and Behavior Change Communication
SCM	Supply Chain Management
SCMS	Supply Chain Management System
SDA	Small Doable Action
SGBV	Sexual Gender Based Violence
SIAPS	System for Improved Access to Pharmaceuticals and Services
SIMS	Site Improvement through Monitoring System
SLT	Senior Leadership Team
SMS	Short Message Service
SOP	Standard Operating Procedures
SP	Sulfadoxine/Pyrimethamine
STA	Senior Technical Advisor
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
SWAA	Society for Women against AIDS in Africa
TA	Technical Assistance
TAG	Technical Advisory Group
TB	Tuberculosis
TOR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
URC	University Research Corporation
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WP	Work Plan
Y2	Project Year 2

Introduction

The *Integrated Health Project in Burundi* (IHPB) is a five-year project (December 23, 2013 to December 22, 2018) funded by the United States Agency for International Development (USAID). Led by Family Health International (FHI 360) as the prime contractor, the IHPB partnership includes two sub-contractors: Pathfinder International and Panagora Group. IHPB builds on USAID's legacy of support to the health sector in Burundi and FHI 360 and Pathfinder's successes in assisting the Government of Burundi (GOB) to expand and integrate essential services for: HIV/AIDS; maternal, neonatal and child health (MNCH); malaria; family planning (FP) and reproductive health (RH).

The Ministry of Public Health and Fight against AIDS (MPHFA) is a major partner that is involved at every step throughout the project planning and implementation. IHPB's goal is to assist the GOB, communities, and civil society organizations (CSOs) to improve the health status of populations in 12 health districts located in the provinces of Karusi, Kayanza, Kirundo and Muyinga. IHPB's expected results are:

1) Increased positive behaviors at the individual and household levels;
2) Increased use of quality integrated health and support services; and
3) Strengthened health system and civil society capacity.

This annual report details IHPB activities and achievements during the nine-month Y2 (23 December 2014 to 30 September 2015) period. Highlights of activities and achievements are presented below:

- Collected and analyzed data for the Household Survey (HHS) - reporting writing underway;
- Convened a validation workshop to present the Communication and Gender Assessment findings to the Department of Health, Hygiene and Sanitation Promotion (DPSHA) and partners. incorporated comments and suggestions, and submitted the Social and Behavior Change Communication (SBCC) Strategy to USAID;
- Developed an Interpersonal Communication (IPC) module and community mobilization strategy and plan;
- Developed an algorithm on clinical management of sexual violence, utilizing the National Manual for the Clinical Management of Cases of Sexual Violence, World Health Organization (WHO) Protocol for the Clinical Management of Cases of Rape, and additional nationally and internationally recognized guidelines and materials;
- Trained 238 (123 female and 115 male) CHWs from Kirundo, in dispensation, storage, distribution, monitoring and reporting of health commodities at the community level;
- Trained 256 (94 female and 162 male) CHWs from Giteranyi health district and 236 (116 female and 122 male) from eight health centers in Kayanza and Gahombo health districts (a total of 492 CHWs) on the delivery of services according to the CHW Integrated Manual and on the new standard community data collecting tools;
- Trained different categories of health workers on various malaria-related themes: new guidelines on malaria case management (86: 39 male and 49 female); community case management of malaria (70: 31 male and 39 female); correct diagnosis of malaria using microscopy (127: 46 female and 81 male); and intermittent preventive treatment (IPTp) of malaria during pregnancy (275: 169 male and 106 female);
- Trained different categories of health workers on various themes related to maternal, neonatal, reproductive and child health: basic emergency obstetrics and newborn care (56: 42 male and 14 female); maternal death audits (56: 38 male and 18 female); essential obstetrics and neonatal care (30: 22 male and 8 female)); modern contraceptive technologies (78: 45 male and 33 female)); youth friendly services (35: 23 male and 12 female); and clinical integrated management of childhood Illness (29: 9 female and 20 male);
- Conducted supportive supervision related to prevention of mother to child transmission (PMTCT), sexually transmitted infections (STI) management, and adherence to anti retro viral therapy (ART) including laboratory units using Site Improvement through Monitoring System (SIMS) tool in 158 health facilities;

- Trained different categories of health workers on HIV/AIDS-related themes: testing techniques (48: 31 male and 17 female); HIV counseling techniques (145: 104 male and 41 female); integration of RH/HIV/PMTCT (401: 256 male and 146 female); syndromic management of STI (252: 156 male and 96 female);and ART protocol (45: 24 male and 21 female);
- Supported quality improvement (QI) activities: training sessions on coaching QI teams to integrate services; coaching visits to support QI Team (QITs) in designing QI process maps;
- Provided support to 3 CSOs in improving management systems, financial management, and human resources management (strategic planning, procedures manuals, HR management manuals, procurement procedures, etc.);
- Contributed to the PBF system of 12 health districts by funding seven HIV/AIDS indicators through monthly payments. During the period January – July 2015, a total of 393,103,484 *Burundi Francs ($254,438)* were paid [1];
- Finalized the pilot study protocol of integration of PMTCT and Early Infant Diagnosis (EID), submitted it to FHI360 Scientific Affairs for review and addressed the comments. It will then be submitted to FHI 360's Protection of Human Subjects Committee for approval;
- Distributed medical equipment worth $1,795,959 to 165 facilities (156 health centers and 9 hospitals) and trained 63 health care providers on on-site preventive maintenance of the equipment;
- Distributed MPHFA-developed guidelines and tools: 200 laminated copies of IPTp implementation guide and 200 algorithms on IPTp across facilities in 12 health districts; 150 algorithms in 10 facilities in Karusi on basic emergency and newborn care (BEmOC); 76 ART guides; 245 PMTCT guides; 70 post exposure prophylaxis (PEP) guides; and 157 HIV testing and counseling (HTC) standard operating procedures (SOPs).
- Submitted a nine-month Year 2 work plan, first annual (23 December – 22 December 2014) report, nine monthly progress reports, two quarterly (January to March and April – June) reports, and PEPFAR Semi Annual Performance Report (SAPR) into DATIM (Data for Accountability, Transparency and Impact) interface;
- Established fully functional sub-offices in Karusi and Kayanza provinces;
- Held preliminary exploratory partnership discussions with potential public and private partners that could complement and support IHPB's work;
- Fostered collaboration and coordination with USG-funded projects and organizations; and
- Within the framework of IHPB staff capacity building, (a) Associate Director for Finance and Administration and Contracts and Grants Officer participation (March 7 to 21, 2015) in a workshop on Grants Management and Administration organized by FHI360 in South Africa; (b) IHPB Senior M&E Advisor and Data Manager attended a five-day workshop (June 7-13, 2015) organized by FHI 360 Home Office (HO) in Addis Ababa, whose core objective was to examine and discuss experiences on data quality and data use and develop action plans for addressing identified challenges and critical issues; and (c) IHPB Reproductive Health Specialist attended the Implementing Best Practices in Family Planning Workshop held in Addis Ababa (June 14 to 19, 2015) where he made a presentation on integration of family planning into maternal and child health services to reduce missed opportunities and improve the quality of services.

[1] Per the 2015 PEPFAR Country Operational Plan (COP), beginning October 1, 2015, IHPB will cease financial and technical support for PBF. Y3 IHPB activities related to PBF will be limited to receiving and paying for relevant health facility performance on seven HIV/AIDS indicators for July, August and September 2015.

The achievements registered in Y2 can be attributed to the excellent working relationship with the central and peripheral structures of Ministry of Public Health and the Fight against AIDS (MPHFA) and the strong support IHPB received from the various technical programs – the National Reproductive Health Program (PNSR), National Integrated Malaria Control Program (PNILP), and Department of Health, Hygiene and Sanitation Promotion (DPSHA) – that availed national trainers and, where necessary, training centers for Basic Emergency and Neonatal Care (BEmONC) and modern contraceptive technology.

Formative Analysis and Baseline Assessments - Progress overview

Planned Y2	Achievement and results	Comments
Finalize HH Survey implementation plans	Achieved	Finalized in January 2015
Conduct mapping and sampling field exercises	Achieved	Sample taken at provincial level Completed in February 2015
Recruit, hire, and train data collectors	Achieved	Completed in February 2015
Pre-test and refine data collection tools	Achieved	Finalized in February 2015
Conduct data collection (Household Survey) in 12 districts	Achieved	Conducted in the 4-supported provinces in April 2015
Support data management and data quality assurance	Achieved	Completed in June 2015
Analyze data and interpret results	Achieved	Completed in September 2015

During the first year (December 23, 2013 to December 30, 2014), IHPB undertook substantial data collection and analyses for formative assessments and baseline (FABs) including the Service Availability and Readiness Assessment (SARA), Facility Qualitative Assessment (FQA), Community Services Mapping (CSM), Communication and Social and Behavior Change Qualitative Study and Gender Assessment, and District/BDS Capacity Assessment. The Household Survey (HHS) and SBC Qualitative Study are together referred to as the demand-side assessments while the SARA, FQA, CSM, and District/BDS Assessment constitute supply-side assessments.

During the second year, IHPB completed the sixth and final FAB, quantitative Household Survey (HHS) whose goal was to provide baseline information on health-related behaviors at the individual, household, and community levels to guide project activities, develop project targets, and furnish measures against which progress towards objectives and outcomes can be measured. A secondary objective was to assess knowledge (including cause and symptoms where appropriate), attitudes, practices (including treatment where appropriate), and self-efficacy in HIV/AIDS; sexually transmitted infections (STIs); maternal, newborn, and child health (MNCH); family planning and reproductive health (FP/RH); gender and gender-based violence (GBV); malaria; malnutrition; diarrheal diseases; and water, sanitation and hygiene. Results from the HHS will be leveraged along with those from other FABs to inform SBCC interventions, project priorities and strategies.

The steps that culminated in the conduct of the HHS are presented below.

***Obtain required approvals**:*

IHPB Year 1 ended with all required authorizations for the implementation of the HHS: (1) project approval from the National Ethics Committee (Nov 4, 2015), (2) the Statistical Visa from the Ministry in Charge of Economic Development Planning (Dec 8, 2014), (3) the authorization of the MPHFA (Dec 30, 2014) and (4) the authorization of the Ministry of Home Affairs (Dec 31, 2014).

In addition, IHPB requested and received approval from Governors of IHPB-supported-provinces in February 2015 before conducting households' enumeration and sampling enabling IHPB to implement and complete

all HHS related activities with the facilitation and support of local authorities at all levels at a time the country was going through a turbulent pre-electoral period.

***Enumeration of Households and sampling (February 16-20, 2015)*:**
In order to prepare household survey data collection, IHPB conducted, during the week of February 16-20, 2015, an enumeration of households on 256 sub-villages (sous-collines) previously randomly selected. Before implementation of the activity, one-day training was conducted to 58 candidates including 6 substitutes. With 52 enumerators deployed (13 in each province) and 12 supervisors (3 in each province including 2 IHPB officers and the Provincial Coordinator of Health Promotion), 2,560 households were randomly selected for inclusion in the survey (10 on each sub-village, 640 in each province).

***Recruited and trained data collectors (February 23-27, 2015)*:**
After households sampling, IHPB conducted a training of data collectors in Gitega, a province not included in the survey, which served for the tool pre-test (Feb 23-27, 2015). Fifty-eight data collectors and 13 supervisors (8 from IHPB, 4 Provincial Health Promotion Coordinators and one from the Department of National Health Information System), completed the training. They were trained on the Research Ethics, the data collection tool, the methodology and data collection using tablets. Of them, the first 48 who passed the test on Ethics Committee with at least 70% were recruited to conduct data collection. Additional 2-day training was organized for supervisors.

***Data collection (March 9 – April 4, 2015)*:**
After having received all required approvals and go-ahead of all administrative authorities and trained data collectors and supervisors, IHPB completed the HHS data collection from March 9, 2015 to April 4, 2015. In close collaboration with the Research Section of the Department of the National Health Information System, the data collection was conducted in the four IHPB-supported provinces by 12 data collectors and 3 supervisors in each. In all, 2,552 households out of 2,560 randomly selected were surveyed, and 4,312 individuals (1,877 males and 2,435 females) were interviewed.

***Data analysis (April 2015 –September 2015) and report writing*:**
Data analysis completed in September 2015 – report writing underway.

Analyze, Use and Disseminate FAB Findings - Progress overview

Planned for Y2	Achievement and results	Comments
Finalize comprehensive data analysis plan	Achieved	Analysis plans developed for each Baseline assessment
Conduct facility-level data verification, as needed	Achieved	Data verification conducted through PBF assessments, and supervision visits
Complete analysis of supply-side data	Achieved	
Produce supply-side sections of situation analysis reports for each BDS		An outline of the district report was developed and started the validation and analysis of data, starting with Muyinga district report
Complete analysis of demand-side data	Achieved	
Meet with each BDS to review, validate and discuss findings from situational analysis	Postponed for implementation in Y3	MPHFA planning process will start in quarter October – December 2015

During the second year, IHPB completed data analysis and report writing for the Services Availability and Readiness Assessment (SARA) and Facility Qualitative Assessment (FQA). Annex III presents a summary of the findings from the aforementioned FABs. Findings from supply-side assessments will be combined with those from demand-side assessments to develop 12 district situation analysis reports.

CLIN 1: Increased Positive Behaviors at the Individual, Household and Community Levels

Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household and community levels - Progress overview

	Planned for Y 2	Achievement and results	Comments
Finalize SBCC Strategy and share findings from SBC Qualitative Study	Convene workshop with DPSHA and other stakeholders to present SBCC Qualitative Study findings and solicit additional input and buy-in on SBCC Strategy	Achieved	Two-day validation workshop (Match 26th and 27th) organized
	Finalize SBC Qualitative Study and SBCC Strategy	Achieved	Final SBCC submitted to USAID on June 29, 2015
Develop campaign and materials using Life Stage Approach	Convene message harmonization workshop for Life Stage 1	Postponed for implementation in Y3	Development of Life Stage materials did not take place due to inability of Graphic Designer to complete the task and subsequent termination of the contract
	Complete first draft of Life Stage 1 materials		
	Pre-test and revise Life Stage 1 materials		
	Finalize and produce materials for Life Stage 1		
	Begin distributing Life Stage 1 materials (Continued in Y3)		
	Plan and conduct Action Media Workshops for Life Stage 2		
Enlist and train community health workers	Develop CHW project brief detailing overall organizational, managerial and logistic plan	Achieved	
	Develop CHW training package, training of trainers curricula and identify elements of the field tool kit	Achieved	IPC Module developed
	Recruit CHW Focal Point Trainers	Postponed for implementation in Y`3	Communication materials were not developed due to termination of Graphic Designer's contract
	Conduct CHW training		
	Conduct phased community roll out (conduct training, distribute communication materials, etc.)	Achieved	
Community mobilization	Establish IHPB internal reporting and supervision system	Achieved	
	Develop overarching community mobilization strategy and plan of action		
	Advertise for and secure a radio drama production house		

	Planned for Y 2	Achievement and results	Comments
Develop and air radio serial drama that reinforces IPC and community mobilization efforts	Develop creative briefs	Postponed for implementation in Y3	Due to lack of response locally, an international request for proposals was issued in September 2015
	Draft design document and story boards		
	Hold stakeholder meeting to prepare creative briefs and design document for script writers		
	Draft script and storyboard for pilot episode		
	Record and pre-test pilot episode		
	Analyze and incorporate pre-test results		
	Develop episodes 1-6		
	Produce, edit, and broadcast episodes 1-6		

Finalize SBCC Strategy and share findings from SBC Qualitative Study

In Y2 IHPB finalized the SBCC Strategy, incorporating findings from SBCC and Gender formative assessments. The Strategy is built on the Life Stage Approach framework which recognizes predictable influences on behavior when transitioning from various life stages, and audiences that directly and indirectly influence health behaviors. For each life stage the Strategy outlines desired behaviors and actions, and barriers to their adoption, which will guide the development of SBCC messages and materials and their communication channels. Related communication objectives are defined along with mutually reinforcing communication interventions using a channel mix including print materials, mass media, community mobilization and interpersonal communication. In partnership with MPHFA (DPSHA/IEC), IHPB organized a two-day (March 26th and 27th) SBCC validation workshop in Kayanza province attended by stakeholders at national and district levels.

Develop campaign and materials using Life Stage Approach

The Life Stage approach separates audiences by recognizing predictable influences on behavior when transitioning from various life stages, such as leaving home, getting married, becoming pregnant and raising children. For example, pregnant women need pregnancy related information, but also tend to be more interested in MCH, PMTCT and FP issues than when they are not pregnant. Similarly, recently married men show more openness to information about family health as they explore new responsibilities as heads of households. In the same line, the SBCC team has undertaken the development of a number of communication materials that address behavioral determinants as described in the strategic framework.

Through the services of a Graphic Designer, in Y2, IHPB began developing communication materials for the first of four planned life stages, e.g. pregnant women aged 18 to 49 and their partners. Due to the inability of Graphic Designer to complete the tasks and subsequent termination of the contract, development of Life Stage materials was not completed. Once another designer is identified, in Y3, IHPB will pre-test and print Life Stage 1 materials.

In Y2, IHPB developed an interpersonal communication (IPC) module that will be used in Y3 to equip Health Promotion Technicians (HPTs) with skills in addressing health determinants and behaviors, facilitation and counseling, and effective use of communication materials. The module outlines the basics of communication concepts, the SBCC approach, the role and quality of a good community actor, counseling and dialogue and use of communication materials.

Community mobilization

Develop overarching community mobilization strategy and plan of action

In Y2 IHPB SBCC team developed a Community Mobilization Strategy and Plan, an internal IHPB project document detailing how a variety of communication interventions will be used to engage community actors[2] to serve as change agents and promote healthy behaviors. The Plan seeks to link demand for and supply of health services by promoting:

- The benefits of serving as change agents;
- Key actions for change agents to adopt and promote;
- The role of CHWs in identifying and recruiting appropriate change agents based on defined criteria; and
- Change agent training curricula and support materials, supervisory system, and tools for monitoring and reporting community-level SBCC activities.

Enlist and train CHWs

The Community Health Operational Brief, which is part of the Community Mobilization Strategy and Plan, indicates that the goal is linking demand and supply of health services by promoting the adoption of key actions, benefits of being an agent of change, role of CHW's in spearheading social change that brings about better health in the communities, selection criteria, identification of the training curricula and their support materials, supervisory system and reporting of SBCC activities.

In the first year, IHPB advertised for a potential local radio drama production house but did not find any bidder. During Y2, IHPB re-advertised for international firms to submit expression of interest and proposal. Mass communication activities will be implemented in Y3 upon reception of a good candidate to partner with.

Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and household - Progress Overview

Planned for Y2	Achievement and results	Comments
Participate in validation of supply chain management (SCM) training manual		MPHFA did not call a validation meeting
Five-day training of 54 HPTs as trainers on SCM	Achieved	57 HPTs and 10 supervisors trained as trainers
2 sessions of 5-day training for 52 pharmacy managers in Kirundo province	Achieved	52 pharmacy managers and 2 from civil society (ABUBEF and ANSS) trained on quantification, stock management, and inventory methods
Adapt the training curriculum for CHW	Achieved	In lieu of training curriculum, slide presentation was developed
Training on SCM for 257 CHWs from	Achieved 93%	238 CHWs trained

[2] While the ''Manuel des procédures de santé communautaire'' recognizes the following community health actors: comité de santé (COSA), community health workers (CHWs), local associations, traditional birth attendants (TBAs) and traditional healers, IHPB will work closely with community health workers.

Planned for Y2	Achievement and results	Comments
Kirundo health district by HPTs		
Participate in MPHFA technical working group (TWG) and committee meetings to advocate for CBD of cotrimaxazole and misoprostol	Informal meetings were held with the National Reproductive Health Program (PNSR) and National HIV/AIDS Control Program (PNLS)	
Provide kits to CHWs for Community Case Management (CCM) of malaria in three health districts	Achieved	Over 800 CCM of malaria kits were provided
Avail vehicles (on as need basis) for timely delivery of commodities to health facilities per district's requests	Achieved	Vehicle and driver provided to Gashoho district based on identified gap impacting supply chain in the district

In Y1-2 IHPB examined facility and district health system capacity and performance in SCM through the analysis of data from the service availability and readiness (SARA), facility quality (FQA) and BDS assessments. Results helped identify bottlenecks at facility, community and district levels and performance gaps and barriers in the supply chain that are the causes of stock-outs of essential medicine and commodities. The SARA found that 62% of supported facilities had experienced a stockout of any sort, and 25% a stockout of FP commodities specifically, over the three months prior to the study. According to the BDS evaluation, major causes of stockouts at district level were stockouts at national warehouse level (reported by 50% of district health staff interviewed), low thresholds for procuring health commodities at district level (33%), poor quantification of stock supply and use at health facilities (8%), and insufficient availability of vehicles to restock supplies (8%).

At community level, the FQA found that only 58% of CHWs have regular supplies of male condoms, 36% female condoms, 14% oral contraceptives, and 15% in insecticide-treated nets (ITNs). Per the FQA, CHWs face a variety of challenges in attempting to avoid stock outs, including lacking of place to keep medicines and commodities (reported by 56% of CHWs surveyed), lack of skills in supply management (53%), and transportation issues (50%).

Using provisionary results from the SARA, FQA and BDS assessments as a basis for planning, in Y2 IHPB's SCM work focused on promoting uninterrupted supply of malaria, neonatal and childhood, family planning, and HIV-related commodities (including ARVs) from central warehouses to communities, via health facilities. Activities were designed and implemented to address identified bottlenecks, gaps and barriers. These include trainings organized in collaboration with health districts and facilities and provision of kits to CHWs in districts implementing community case management of malaria (CCM). To address recurrent stock outs in Gashoho District due to lack of transport, IHPB provided the district with a vehicle after jointly signing a contract concerning vehicle assignment, management, and maintenance.

Y2 SCM achievements include the following:

- Training of trainers (ToT) in SCM for community services: 57 HPTs and 10 district supervisors (57 male and 10 female) were trained using sections of MPHFA's Management Tools and Logistics of Pharmaceuticals, February 2015.
- Training of 54 pharmacy staff (30 female and 24 male) in Kirundo health province trained in quantification, stock management, and inventory methods.
- 238 Community Health Workers (123 female and 115 male) from Kirundo health district were trained in dispensation, storage, distribution, monitoring and reporting of health commodities at community level.
- SCM supplies: 484 CHWs in Gashoho (160), Gahombo (242) and Kirundo (72) health districts supplied with notebooks, stock cards, gloves, saddlebags, safety boxes, and solar lamps to facilitate effective supply management in areas implementing CCM for malaria; and
- Transport: Vehicle, driver, and maintenance procured and provided to Gashoho District based on identified gap impacting supply chain.

Sub-CLIN 1.3: Strengthened support for positive gender norms and behaviors and increased access to GBV services

Sub-CLIN 1.3.a: Strengthened support for positive gender norms and behaviors Progress Overview

Planned for Year 2	Achievement and results	Comments
Analyze gender-related data from FABs to inform gender assessment and strategy	Achieved	
Conduct policy analysis to identify facilitators and barriers to service utilization and health-seeking behaviors	Achieved	
Draft gender assessment report	Achieved	The Gender Assessment Report was shared with partners in a workshop
Integrate gender themes into SBCC strategy and activities	Achieved	SBCC Strategy integrates gender dimension
Consult with partner organizations to identify opportunities to collaborate on delivering gender norm and male involvement interventions	Achieved	
Provide gender integration training to IHPB staff and identify opportunities to further integrate gender into project	Postponed for implementation in Y3	Planned STTA provider travel did not take place due to travel ban
Develop gender strategy in collaboration with project leads		
Design and implement additional activities to address priority gender gaps per gender strategy (continue in Year 3)		

Gender Assessment and Policy Analysis

In Year 2 IHPB completed a Gender Assessment to identify gender disparities and inequalities affecting health-seeking behaviors, the perpetration of GBV, and survivors' utilization of a multisectoral package of services (e.g., health, psychosocial and legal support, etc.). The assessment examined how gender roles, norms, and inequities affect the health of women, men, and children in the context of the Integrated Health Project in Burundi. The gender assessment synthesized information from:

- Key informant interviews with public health experts in Bujumbura (19 organizations and individuals);
- 26 focus group discussions with community members, service providers, and CHWs in IHPB focus provinces;
- 17 in-depth interviews with men who have sex with men (MSM) and female sex workers (FSWs) in focus provinces; and
- A review of relevant health and gender data and policies for Burundi.

The Gender Assessment and analysis of existing gender policy found that gender norms, roles and relations are strong determinants of health for individuals and communities in Burundi. Gender inequality limits women's and girls' access to information, decision-making power, economic assets, educational opportunities, social capital and other health and development resources in country. Women with limited education were at significantly elevated risk for GBV. The low social status of women and young girls constitute barriers to socio-economic resources, which affects their access to health services, even as women are the primary household member responsible for family healthcare. The role of men is to financially support the family. This social status gives men the decision-making power and control over household financial resources. Women and girls are also at higher risk of HIV because of their limited ability to negotiate protected sex. With regards to reproductive health and family planning, discussions around FP among couples, is not common. As for key populations, female sex workers (FSW) and men who have sex with men (MSM), the assessment revealed that this category is extremely vulnerable to HIV and STI and faces very high stigma in their communities.

On 26-27th March, 2015 the Gender Assessment Report was shared with all the project partners: MPHFA, USAID, partner CSOs, religious leaders and NGOs and feedback and comments have been integrated in the final report. The sharing workshop was held in Kayanza Province. In total 53 people participated. The workshop offered a good opportunity to identify, among partners, opportunities to collaborate on delivering gender norm and male involvement interventions. In order to strategically plan for gender integration into project activities, IHPB has established contacts with USG-funded organizations such as International Medical Corps, EngenderHealth, and the Ministry in Charge of Gender to allow the flow of information for planning and implementation purposes.

Gender Strategy

The gender strategy to be developed by the project will utilize the results of the gender assessment to define an action plan for more thoroughly integrating gender into project activities, as well as guidance for measuring and ensuring the project's progress towards achieving gender integration results. The gender strategy will be developed in collaboration with project and STTA leads across programmatic and technical areas, with input from USAID and other international and local organizations. Because of inability of STTA providers to be in country, FHI 360 and Pathfinder International HQ have already joined hands to develop a draft strategy remotely and the final version will be available once the STTA is rescheduled and the strategy is adapted to fit Burundi context.

Gender Integration Training

With the objective of increasing staff understanding of gender norms and inequalities and how they affect health outcomes, and identify opportunities to address gender themes (e.g. male norms, GBV, service equity, power imbalances within the household, etc.) across IHPB interventions and technical strategies, gender integration training to IHPB staff planned for implementation in Y2, has been postponed for implementation in Y3.

Sub-CLIN 1.3.b: Expand access to high quality comprehensive services for GBV survivors – Progress Overview

Planned for Y2	Achievement and results	Comments
Coordinate and provide support for supportive supervision visits for 12 health centers and facilities supported for GBV services under Flexible FP (in Muyinga Province)	Achieved	
Coordinate and provide support for supportive supervision visits for 12 facilities by newly trained health providers in Kirundo Province		Training conducted in August 2015. Supervision will commence November 2015
Finalize jobs aid for GBV clinical case management for health providers and share with MPHFA for validation	Achieved	
Disseminate finalized, validated GBV clinical case management job aids to facilities supported for GBV services		Validation and dissemination planned for Y3
Identify healthcare and multisectoral providers from Muyinga District and Kirundo Province to be trained	Achieved	
Identify two ART or PMTCT sites in Muyinga District for piloting integrated package of GBV services	Achieved	
Work with Centre Seruka to plan, prepare for and conduct trainings on GBV case management for identified health and multi-sector providers from Muyinga and Kirundo Provinces	Achieved	
Collaborate with Burundians Responding Against Violence and Inequality (BRAVI) to review and provide inputs on development of additional job aids, tools, and training curricula for clinical management of GBV cases	Achieved	Draft of algorithm on GBV case management shared with BRAVI
Collaborate with BRAVI for quarterly multi-sectorial coordination meetings with stakeholders engaged in GBV prevention and response in Muyinga District		Early discussions held with BRAVI
Link with activities under Sub-CLINs 1.2, 3.1 and 3.2 to strengthen collection of GBV service data and commodity supply change management specific to essential commodities for GBV case management	Achieved	

In Y2, IHPB worked closely with BRAVI, PNSR and Seruka Center to increase access to and quality of a multi-sectorial package of services for GBV survivors and to ensure that activities are mutually reinforcing and complementary. Key Y2 achievements include:

- Muyinga-based IHPB Technical Officer, in partnership with Muyinga district staff, conducted an integrated supervision visit of 16 health centers in the health district of Giteranyi,. It was observed that most health facilities have one provider trained in SGBV case management; it was recommended that a second health provider be trained.
- Developed an algorithm on clinical management of sexual violence, utilizing the National Manual for the Clinical Management of Cases of Sexual Violence, WHO Protocol for the Clinical Management of Cases of

Rape, and additional nationally and internationally recognized guidelines and materials. IHPB shared the draft with PNSR and Engender Health/BRAVI for input. Validation of the job aid is planned during the quarter October – December 2015

- In line with proposed IHPB plans to pilot a multi sectorial approach to primary and secondary prevention of GBV in Muyinga province, and in response to provincial interests to integrate clinical services for GBV survivors into existing services in Kirundo, IHPB organized a five-day training session for 30 health care providers (25 males and 5 females) from Kirundo (23 health providers) and Muyinga (7 health providers) on clinical management of GBV usingthe national l "*manuel de formation sur la prise en charge globale des victimes des violences sexuelles et violences basees sur le genre*" of the MOH. Trainers were from the national program of the reproductive health "PNSR" and the Ministry in charge of gender.
- Held series of meetings with BRAVI to forge collaborative partnership and discuss elaboration of supervision tools and learned that BRAVI will be recruiting a consultant to develop tools including, but not limited to, supervision. IHPB presented the algorithm on GBV case management, which is planned to be validated during the quarter October – December 2015.
- During the Y2, data from 26 health facilities (9 hospital and 17 health centers) reported that 123 survivors (113 female and 10 male)[3] received anti-retroviral therapy for post exposure prophylaxis.

CLIN 2: Increased Use of Quality Integrated Health and Support Services

Sub-CLIN 2.1: Increased access to health and support services within communities:
Progress Overview

	Planned for Y 2	Achievement and results	Comments
Strengthening COSAs	Support the BDS to provide a 5-day training to 90 members of 30 COSAs	60 members of 20 COSAs trained	
	Enable the BDS to organize an experience exchange visit for 30 members of COSAs to a well-functioning COSA	Planned for implementation in Y3	
Strengthening community health workers	Support the BDS to conduct 5 day ToT on CHW manual and data collection tools for 24 trainers from Giteranyi district and Kayanza province	Achieved	
	Support 5-day trainings on CHW Integrated Manual and data collection tools for 575 CHWs from Giteranyi and Kayanza	Achieved	
	Provide CHWs with working guides and data collection tools	Achieved	
	Mentor CHW groups' biannual planning in Giteranyi and 12 health centers in Kayanza province	Achieved	
	Enable the BDS to hold CHW quarterly meetings at HC in Giteranyi and 12 health centers in Kayanza province	Achieved	
	Support the BDS to conduct 5-day ToT for 22 trainers from Nyabikere health	Achieved	

[3] Source: IHPB data: January to June 2015.

	Planned for Y 2	Achievement and results	Comments
	districts on malnutrition screening and emergency nutrition assessment (ENA)/Infant young child feeding (IYCF)		
	Support the BDS to conduct 3-day trainings of 166 CHWs from Nyabikere health districts on malnutrition screening and ENA/IYCF	Achieved	
	Provide 166 CHWs with MUAC tools	Achieved	
	Conduct integrated supervision of CHWs including malnutrition screening and follow-up on discharged malnutrition cases in Nyabikere Health District	Postponed for implementation in Y3	Training of CHWs on malnutrition took place in September
	Assist the BDs to organize semi-annual CHW meetings to follow-up on community health activities in Kayanza and Muyinga provinces	Achieved	
	Support the biannual coordination meetings at provincial level on community health system	Achieved	

Strengthening COSAs:

The Government of Burundi established a system of community participation in managing health facilities by setting up health committees. Thus, each health center (pubic and faith-based) has a health committee comprising members from each colline of the catchment area. However, created around the year 2000, the health committees system suffers from several difficulties - Some COSAs members didn't have orientation training and not aware of the package of activities they are responsible for including not have training on health center management. According to SARA that used COSAs functionality criteria defined in the Manuel des Procedures pour la Santé Communautaire, 48 COSAs revealed nonfunctional: 19 in Kirundo, 12 in Kayanza, 10 in Muyinga, and 7 in Karusi.

During Y2, IHPB in collaboration with the DPSHA of the MPHFA and provincial and district health staff, supported a 4-day training on COSA and health center management for 60 members of COSAs from 20 health centers, using the *Curriculum de Renforcement des COSAs,* the *Manuel des Procédures Administratives, Financières et Comptables du Centre de Santé,* and the *Manuel des Procédures Santé Communautaire.* The topics covered include: history of COSAs (History); COSAs Organization and duties; techniques of conducting meetings; health centers action plans; pharmacy and financial management; matrix indicators of the COSAs functionality. COSAs from 20 health centers chosen to implement integration in Kayanza and Kirundo provinces were chosen (10 in Kayanza, and 10 in Kirundo) benefitted from the 4-day training.

Strengthening CHWs system:

Community Health Workers (CHWs) provide a critical and essential link with health systems and are a powerful force for promoting healthy behaviors in resource-constrained settings. However, the CHW system in Burundi suffers from challenges that include weak planning and supervision of community based activities by health workers and unclear reporting system and weak collaboration between facility-based health workers and CHWs.

During Y2, IHPB in collaboration with the MPHFA,

- Trained 256 (94 female and 162 male) CHWs from Giteranyi health district and 236 (116 female and 122 male) from eight health centers in Kayanza and Gahombo health districts (a total of 492 CHWs) on the CHW Integrated Manual and on the new standard community data collecting tools;
- Conducted missions to health centers to coach CHWs on work plan elaboration;
- Held meetings of CHWs at administrative commune level to discuss on community activities issues: In Kayanza, 801 CHWs (433 female and 368 male) from all nine communes attended whereas in Muyinga, 680 CHWs (293 female and 387 male) attended the meetings;
- Trained 184 (70 female and 114 male) CHWs from Nyabikere health district on community-based management of acute malnutrition (screening, referral, and nutritional education) and provided CHWs the tools they would need to start activities. The benefit of the activity is that the number of cases screened and the number of referred for malnutrition will increase;
- Held one coordination meetings at provincial level in Kayanza and Muyinga, where community health system issues were debated and solutions proposed including clinical services managers and community services managers committed to collaborate and allocate fairly resources.

Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services

2.2. C: Support integration with a QI model and prepare districts for scale-up of best practices - Progress Overview

Planned for Y2	Achievement and results	Comments
Develop the material needed for the QI orientation and training workshop	Achieved	
Conduct four three-day provincial QI orientation workshops	Achieved	
Organize 4 three-day training sessions to train QI coaches	Organized sessions in Karusi, Kayanza, and Kirundo	Muyinga session planned for Quarter 1 in Y3
Conduct first joint coaching visits to establish QI teams	Coaching visits conducted in Karusi and Kirundo	Kayanza and Muyinga visits will be conducted in Y3
Conduct monthly QI coaching visits	Achieved	Coaching reports submitted by Karusi (5), Kayanza (2) and Kirundo (1)
Organize one quarterly learning session per province		Learning session is organized usually three months after first joint coaching visits Learning sessions will start in Y3
Develop documentation support and start documenting QI efforts		Will start after the first learning session
Train 15 health care workers on FP in Kayanza Province	Achieved	Training service providers was part of the integration strategy to expand the supply of services
Train 11 health care workers on FP in Karusi	Achieved	
Train 19 health workers on PITC in Kirundo	Achieved	
Train 19 health workers on GBV in Kirundo	Achieved	
Train 11 health workers on provider initiated testing and counseling (Karusi)	Achieved	

In Y2 IHPB continued to support integration of services according to the plan developed in 2014 around the Collaborative Model for Improvement across 49 health facilities in the project's four focus provinces. Analyses of data collected through the FQA and SARA were finalized and the outcomes used to quantify integration gaps as a baseline for QI teams. The SARA found the following levels of service integration among priority areas identified by QI teams:

- FP services are integrated in 91% of ANC consultations, 90% of child immunization services, 84% of maternal health services, and 26% of HIV care;
- HTC is integrated in 85% of maternal and child curative consultations;
- Early ANC is integrated in 76% of child curative clinics; and
- HIV early infant diagnosis (EID) is integrated in 48% of child immunization services.

The FQA also collected information on the main challenges service providers noted regarding delivering integrated services:

- When the same provider must deliver multiple services to a patient during the same consultation, it results in longer client waiting time (reported by 73% of surveyed providers) and heavier workload (67%);
- When clients receive multiple services from different providers during the same visit, it results in longer time spent at the facility (73%); and
- There are an insufficient numbers of providers to deliver all target integrated services in the same visit (67%).

The FQA also found that 76% of those surveyed had not been trained in QI approaches, and 64% found a heavier workload as a result of being engaged in QI efforts.

In Y2, in partnership with the MPHFA, IHPB:

- Developed materials (QI charters, model of service integration plan, job aids for QI team, job aids for organization of QI meetings, job aids for meeting report, QI team functionality follow up form, decision making form, data collection sheet, etc.) needed for QI orientation and workshops.
- Conducted 4 two-day provincial orientation workshops attended by 102 participants (25 female and 77 male) - purpose was to provide an orientation to provincial and district actors on implementation of QI and integration charters.
- Organized three four-day training sessions on coaching of the QI efforts to integrate services: Karusi session was attended by 15 (2 female and 14 male) participants - supervisors from provincial and district health offices (3), hospital directors and chief of nursing (2), in-charge of health centers(11); and Kayanza session was attended by 31 participants (8 female and 23 male) - supervisors from provincial and district health offices (7), hospital directors and chief of nursing (6), in-charge of health centers (16) and IHPB provincial office staff (2). The Kirundo session was attended by 31 (5 female and 26 male) participants - supervisors from provincial and district health offices (9), hospital directors/delegates and chief of nursing (2), in-charge of health centers (17), and IHPB provincial office staff (4).
- Organized five-day coaching visits each to Karusi and Kirundo (June 22-26, 2015) provinces. The purpose of the visits was to help facilities in: designing the quality improvement process map, identifying problems and finding local solutions, setting improvement goals, forming the correct team, analyzing their system, identifying ideas for changes and test changes, and collecting and analyzing data to measure the effects of these changes. By the end of Y2 IHPB has succeeded in establishing 28 QI teams across six districts in three provinces, and a network of district-based coaches to support them.
- Organized five-day training on FP counseling for integration of FP in immunization service. The purpose was to provide knowledge to health providers on family planning counseling. In fact, one of the integration opportunities in their service integration plan model is integration of FP in child immunization

services in health centers and pediatric services in district hospitals. Therefore, the training targeted immunization services providers from health centers and pediatric services providers from district hospitals whereby 26 health care providers 15 in Kayanza Province and 11 in Karusi province were trained.

- Organized a six-day training of trainers on the Integration of RH/HIV/PMTCT services that brought together over 35 participants from the four IHPB target provinces.
- Organized five-day training on GBV in Kirundo and Muyinga. Training targeted 31 participants – Kirundo (17), Muyinga (6) and IHPB staff Kirundo and Muyinga 8). The purpose was to provide knowledge to health providers on GBV case management from curative services.
- Organized five-day training on PITC in Kirundo. Training targeted 31 participants – health centers (15), hospitals (8) and districts (8). The purpose was to provide knowledge to health providers in order to be able to counseling and testing HIV in curative services.

Sub-CLIN 2.3: Increased capacity of providers and managers to provide quality integrated health services: Progress overview

Planned for Y2	Achievement and results	Comments
Develop a project-wide training plan and database	Achieved	Mention the number of trainings achieved
Develop a project-wide calendar of supervision visits (jointly with district supervisors)	Achieved	IHPB follows district supervision calendar
Develop SOPs and tools for coordinating and monitoring supervision activities	Draft SOP developed	To be finalized in Y3. Tool for use by IHPB
Identify a HRH management computerized database appropriate for the district	Achieved	Mention the one identified by the MOHFA
Support districts to develop their capacity-building plan during their annual planning		Planned for October – December 2015, when districts start their planning process

The overall management of health-related human resources (HR) in Burundi remains a highly centralized function performed by the MPHFA Human Resources Department. Results from the BDS survey revealed that HR-related responsibilities of district health management teams are limited to transfer of personnel across facilities within districts, approval of inter-district transfers, and assessment of provider performance, in an overall context of an insufficient quantity of qualified human resources for health (HRH).

Regarding the role of the district teams to strengthen HRH capacity, the BDS survey revealed the following:

- District medical officers are responsible for identifying training needs through supervision visits;
- Most districts do not have in-service training plans for their staff;
- Planned in-service training activities are often cancelled due to lack of funds in district budgets;
- Most in-service training workshops are funded by partners; and
- Multiple parallel HR capacity strengthening plans result in last-minute reprogramming of activities.

Supervision visits provide a good opportunity to support the development of HR capacity through on-the-job training and post-training follow-up on performance. However, 75% of district staff surveyed reported not having or using the national supervision checklist. Supervision visits, theoretically planned to cover each FOSA quarterly, do not always happen and, when they do, rely heavily on partners to provide logistic support and resources required.

During the second year, IHPB,

- Developed an Excel-based spreadsheet for tracking trainings conducted by IHPB , problems encountered and, solutions proposed;
- Drafted Standard Operating Procedures (SOPs) and tools for updating training plans (coordinated planning) and database (monitoring implementation). During the quarter October – December 2015, IHPB will conduct internal validation of the SOP;
- With respect to Identifying a HRH management computerized database appropriate for the district, based on the discussions IHPB has had with MPHFA, the Human Resources Department of the MPHFA, with support from Belgian Technical Cooperation (BTC), has identified and ordered a human resources management software and recruited a firm to manage and roll out trainings, beginning with the installation of the software at the central level.

CLIN 3: Strengthened Health Systems and Capacity

Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas - Progress Overview

3.1. a. Work with provincial and district health bureaus to progressively strengthen district level capacity and performance in managing the decentralized health system

Planned for Y2	Achievement and results	Comments
Provide support during the annual work planning process		The annual district planning process did not start before the end of Y2
Provide, through sub-grants, financial support to organize quarterly coordination workshops at the district level	Achieved	5 districts quarterly coordination workshops were organized with IHPB financial support in (name of districts)
Strengthen the supportive supervision system	Achieved	IHPB provided logistic support to supervision visits through sub-grants that cover the recurrent costs of supervision
Provide medical equipment to health facilities as per needs assessment	Achieved	Equipment worth $1,795,959 provided to 165bfacilities – 9 hospitals and 156 health centers
Train 66 health providers in preventive maintenance	Achieved 95%	63 health workers trained

In Y2 IHPB finalized the data analysis for the health District Health Assessment (BDS survey) which focused on 11 management functions for each of the 12 BDSs assessed. The survey involved interviews of district health team members and document reviews with a focus on the issues, their causes, and ideas to address them. The assessment helped identify capacities needed to address systemic issues. Variations between district offices will be captured in the district-specific reports (which will include results from other surveys such as SARA). BDSs also face common issues across all management functions that, directly or indirectly, affect the delivery of health services at facility and community levels, namely:

- Leadership and governance function: poor planning resulting in duplication and cancellation of activities;
- Human resource management: in-service training needs and activities not tracked and dysfunctional supervision system ;
- Supply chain management: lack of skills, resulting in frequent stock-outs of drugs and consumables;
- Health information system: lack of data quality control, resulting in poor data quality and limited data use;
- Infrastructure and equipment: deficiencies in number and maintenance of needed equipment;
- Service delivery: limited knowledge and use of quality management models.

IHPB worked collaboratively with district health management teams to start addressing weaknesses identified in four management functions: (a) low planning capacity; (b) poor district leadership in coordination mechanisms; (d) poor supervision capacities of district health teams; and (e) lack of maintenance of equipment. IHPB planned to strengthen the capacity of districts to develop their annual work plans but, at the date of this report, the MPHFA has just begun the planning process for FY16. As the process launches, IHPB will support districts through the use of sub-grants to organize several planning workshops, and the use of data for evidence-based planning, including data from the FABs, the health information system (GESIS) and PBF.

In Y2 other achievements of IHPB are the following:

- Supported health districts through the IHPB sub-grants mechanism to organize quarterly coordination meetings in Y2 (IHPB supported five district-led quarterly coordination meetings through the participation of technical staff and funding from sub-grants. Health and non-health sector partners participate to these meetings. IHPB attended the coordination workshops and reported on progress of activities, results, and implementation issues. While the health districts of Buhiga, Nyabikere, Gashoho, Giteranyi and Muyinga were able to request and organize quarterly coordination meetings, three out of the 12 target districts (Gahombo, Kayanza and Musema) didn't request for funds, while four health districts in Kirundo (Busoni, Kirundo, Mukenke and Vumbi) continue to get support from the Belgian Technical Cooperation and World Vision supports three districts in Muyinga province.
- Provided logistic support to supervision visits through sub-grants that cover the recurrent costs of supervision. IHPB field officers also actively mentor district supervisors during visits by providing feedback and coaching on ways to strengthen their supervision practices.
- Provided essential equipment to health centers and district hospitals. With the arrival (in-country) of the equipment ordered by IHPB (USD 2,157,604), IHPB developed a provisional equipment distribution plan along with an inventory of health providers to be trained for the use and maintenance of equipment. Medical equipment ordered by IHPB was received and, after verification of conformity, IHPB started its distribution in the districts. In addition, IHPB is covering the costs of a maintenance contract for the first year. 45 health providers, 9 technicians and 12 supervisors of health district have been trained for on-site preventive maintenance.

3.1. b – Provide essential technical and financial support for PBF – Progress Overview

Planned for Y2	Achievement and results	Comments
Amend and sign standard grants with 12 target BDS for funding seven HIV/AIDS indicators of the Burundi PBF scheme	Achieved	
Monitor and verify facility performance	Achieved	
Make monthly payments to facilities based on performance against seven HIV/AIDS indicators	Achieved	
Renew BDs subcontracts for Y3		Following PEPFAR 2015 COP changes, IHPB will not be supporting PBF activities after September 30, 2015
Provide feedback to BDSs on the payments made	Achieved	

Key Y2 achievements include: Amended, as part of standard grants, and supported 12 health districts for funding the seven HIV/AIDS indicators in the Burundi PBF scheme and made monthly payments. During the period January – July 2015, a total of 393,103,484 *Burundi Francs ($255,000)* were paid.

Per the 2015 PEPFAR COP, in Y3 IHPB will cease financial and technical support for PBF. As a non-core activity that does not directly contribute to increasing treatment coverage and PEPFAR request to transition out PBF activities, Y3 IHPB activities related to PBF will be limited to receiving and paying for relevant health facility performance on seven HIV/AIDS indicators for July, August and September 2015.

3.1. c – Provide TA to help strengthen the Burundi PBF scheme – Progress Overview

Planned for Y2	Achievement and results	Comments
Participate in the CTN quarterly meetings	Achieved	
Provide technical and logistical support for data verification and validation processes in Muyinga province	Achieved	From May 2015, this activity was assigned to a local NGO named COPED (Conseil Pour l'Education et le Développement)
Support the follow up (supervision) of the community survey in Muyinga province	Achieved	
Support semi-annual refresher training of 256 CBO members conducting community surveys in Muyinga	Achieved	
Advise BDSs and facilities in Muyinga on how to present results to and elicit support from communities	Achieved	
Coach health facilities in PBF in Muyinga province	Achieved	
Work collaboratively with the CT-FBP to adapt Community PBF manual of procedures used in Makamba	Achieved	
Prepare IHPB-CHW Support Group (*Groupement d'Agents de Santé Communautaire*) contract templates for community PBF implementation	Achieved	
Collaborate with CT-FBP to validate Community PBF manual of procedures		Due to impending PBF changes, this activity that was planned for September did not take place
Obtain written request from the MPHFA to implement pilot community PBF in Gashoho Health District	Achieved	
Elaborate protocol for community-based PBF pilot in Gashoho	Achieved	
Develop community PBF pilot costing forms	Achieved	

In addition to participating in the quarterly meetings called by the CTN and providing logistics support to the Muyinga CPVV until April 2015, during Y2, IHPB achievements in PBF in collaboration with the MPHFA (central, provincial levels) are:

- 15 facilities were visited and coached in PBF implementation. It was discovered that facilities are utilizing PBF earned funds to improve quality of infrastructure and purchase small equipment.
- The CPVV of Muyinga was supported to conduct quantitative verification and validation of data until April 2015 thereafter this activity was handed to COPED.
- Conducted the half-annual refresher training workshop for local association surveyors which was attended by 230 surveyors (43% females and 57% males) in January and 174 surveyors (99 males and 75 females) in September.
- Conducted two quarterly quality knowledge sharing (restitution) workshops in Muyinga province which were attended by 124 persons (33 females and 91 males) in February and 137 people (35 females and 102 males) in June.
- On April 10th, 2015, IHPB held a technical meeting in Bujumbura with the PBF National Unit (CTN-FBP) of the MPHFA about community PBF implementation tools. Following that meeting, it was agreed that IHPB should use the available community and PBF guidelines in its intervention area: *Manuel des procédures FBP Communautaire*, *Orientations stratégiques en santé Communautaire*, and the *Manuel de l'agent de santé communautaire (Kirundi)* to guide the implementation of community PBF in Gashoho district.

Sub-CLIN 3.2: Strengthened M&E and data management systems at facility and community levels:

Progress overview

Planned for Y2	Achievement and results	Comments
Develop performance improvement plans for district M&E systems strengthening		No project-specific district plan was developed as such for the sake of integration. Instead, IHPB maintained support of M&E activities through the district in-kind grants
Work with the National Program for AIDS Control (NPAC) and Health Districts to introduce and implement updated data collection tools	Achieved	IHPB supported all 12 health districts to introduce the tools in all health facilities and train health providers to use the updated tools
Work with the Department of National Health Information System (DNHIS) and the NPAC to set up an electronic database for HIV-related data at district level	Achieved	IHPB worked with the NPAC, the DNHIS and Measure Evaluation which provided technical assistance in finalizing a GESIS-HIV database for the district level
Train BPS and BDS staff on conducting routine DQAs and/or M&E System Assessments (MESATs)	Achieved	The activity was completed on October 1-2, 2015: 15 HIS cadres were trained on Routine Participatory Data Quality Assessment (RPDQA)
Conduct routine facility-based data quality verification		Planned for implementation Oct 5-16, 2015
Participate in routine data quality assurance exercises and supervisions	Achieved	Activity was completed through support of district quarterly data analysis meetings and routine formative supervisions

During Y2, IHPB contributed to M&E and data management strengthening at facility and community levels in partnership with various counterparts including the Department of National Health Information System (DNHIS), the National Program for AIDS Control (NPAC), MEASURE Evaluation and Health Districts.

On February 18, 2015, IHPB Senior Technical Advisor attended a meeting jointly organized by the National Health Information System Director and the National Program for AIDS Control. The purpose of the meeting was to review HIV services related tools in order to get them compatible with the parameterization of DHIS II. A consultant from the Belgian Technical Cooperation was invited to present his suggestions. Waiting for the integration process, a GESIS-HIV database previously developed with the Belgian Cooperation was finalized with USAID support (Measure Evaluation) and was ready to be implemented with IHPB support within target provinces.

Taking advantage of trainings of health providers organized on HIV services related topics, M&E officers conducted training sessions on the use of updated M&E tools for 506 attendees of the following trainings:

- 100 participants (52 males, 48 females) to a training session on Syndromic Management of STIs in Muyinga (36) and Kayanza (64);
- 43 health providers (28 males, 15 females) attending a training on HIV counseling and testing in Karusi province;
- 363 health providers (220 males, 143 females) attending training on HIV testing and counseling and integration of reproductive health, family planning and PMTCT (87 in Karusi, 63 in Kayanza, 78 in Kirundo and 135 in Muyinga)

On a regular basis, the M&E technical officers participated in the monthly data validation meetings of the Provincial Verification and Validation Committee for the Performance Based Financing System and in the quarterly data analysis workshops organized by each district. Results of these analysis workshops guide

formative supervision objectives implemented during the following quarter. In fact, formative supervisions on the use of newly introduced HIV services tools and data quality assurance were conducted in 66 health facilities across the four supported provinces.

Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated Services: Progress overview

Planned for Y2	Achievement and Results	Comments
Conduct five-day training on leadership and management for 12 board members and 16 senior staff from four focus CSOs	Achieved	
Conduct five-day training for 16 CSO staff on financial management, procurement procedures including USAID management procedures	Achieved	
Provide support to CSOs in improving management systems, financial management, and human resources management (strategic planning, procedures manuals, HR management manuals, procurement procedures, etc.)	Achieved	
Ensure conduct of a 5-day training for 40 leaders from most at-risk populations (MARP) (MSM, FSW and prisoners) and RBP+ personnel on the directives and approaches of the interventions including the package of services		Early discussion with MARP leaders conducted
Ensure the conduct a 5-day training for 30 youths and female peer educators from SWAA Burundi on the different reproductive health topics in Muyinga and Kayanza provinces	Achieved	
Supervise the IIP implementation	Achieved	
Measure quarterly the progress of the capacity strengthening work using the Local Partner Transition (LPT) criteria for graduation	Achieved	
Conduct capacity assessment workshops to measure progress	Activity planned for Year 3	

Under this Sub-CLIN, IHPB seeks to support the further development of key CSO technical and organizational capacities needed to plan, oversee, manage and deliver integrated and improved services in an effective, efficient and responsive decentralized health system. Ownership of the capacity-strengthening process for civil society partners is critical to achieving USAID's desired outcome that CSOs be direct recipient of USAID funds. IHPB ensures that participating CSOs realize measurable and sustainable improvements in both technical and organizational capacities. Initially, IHPB planned that at the end of Y2, three CSOs would be equipped to directly manage USAID funds. Pursuit of these plans is intended to facilitate partners' progression towards direct USAID or other donor funding and the sustainability of both the local partners and the core services they provide within communities.

In Year 2, IHPB supported the 3 CSOs (ANSS, SWAA Burundi and RBP+) to achieving the following activities:

- Through the IHPB support, CSOs carried out activities which contributed to achieving project results as convened in project sub grants. They are specific according each CSO: (1) ANSS achieved activities related to supporting PLHIV (HTC, ART, PMTCT, EID, TB) , women using contraceptive methods, GBV survivors, FSW and MSM ; (2) RBP+ achieved activities related to supporting OVC and their families; (3) SWAA Burundi achieved activities related to improving health behaviors and treatment for FSW and comprehensive case management for GBV survivors

- IHPB utilized a variety of approaches, techniques and strategies to strengthen the capacities of local organizations (ANSS, SWAA Burundi and RBP+) including informal, formal, individual and group activities that increase knowledge, build skills, create systems, allow sustainability and enhance linkages. 15 participants (5 from RBP+, 5 from SWAA Burundi and 5 from ANSS) were trained on leadership and management for CSO board members and senior staff to improve the vision, direction and management of the organizations. Board members come from different sectors and most of them lack professional backgrounds in organizational management. During baseline assessments, governance was identified by nearly all organizations as critical to performance, both in the short-term (for oversight) and long-term (for strategic planning and responding to a changing environment). Therefore a number of activities, including a mix of formal trainings and consistent engagement through feedback and coaching, focused on enhancing the management style and capacities of board members and senior staff.

- In order to strengthen RBP+ capacities, IHPB team conducted training on the database of OVC project implemented by RBP + for RBP+ officers. The database has been installed on computers of these officers. Therefore the data entry will be done easily and reports about the health support, school support, psychological support, nutritional support, legal assistance and assistance for accommodation can be generated automatically.

- With IHPB's emphasis on facilitating the transition of CSO partners to direct USAID funding, a focus on financial management is necessary. Following the CSO capacity assessments, financial management emerged as an area where staff needed strengthening, in addition to supply management and USAID procedures. Therefore, IHPB and PMTCT Acceleration Project staff jointly held a four-day training session on those topics. In total 31 CSO staff members (14 male, 17 female), executive coordinators, finance managers and human resources managers from six CSOs (ANSS, SWAA Burundi, RBP+, ABUBEF, Service Yezu Mwiza and Croix -Rouge du Burundi) participated in the training. Having a fully functioning financial system, competent personnel with the appropriate governance structures and internal controls not only impacts day-to-day organizational performance, but supports efforts to diversify funding and increase the confidence of external stakeholders.

- In 2014, CSOs were assessed using the Institutional Development tool (IDF) focused on technical and organizational domains. In November 2015, assessment workshops will be conducted in the 3 CSOs supported by IHPB in order to measure progress gained after the workshops conducted in August 2014 and therefore to appreciate if they can transition to direct funding from USAID.

Quantitative and qualitative methods described in Local Partner Transition criteria were used to measure progress during each stage of capacity strengthening. The criteria include: (1) The CSO must meet the legal requirements and be recognized by Government; (2) The organization must demonstrate a clear separation of governance and executive functions; (3) The organization must be in good standing with FHI360; (4) The organization must have a well-established accountability and policy framework; (5) The organization should demonstrate basic proficiency in areas necessary for successful management of USAID Cooperative

Agreements. Through progress assessments with partner organizations, IHPB identified needs for course corrections to activities and programs. CSOs have been assessed with the Non-U.S. Organization Pre-Award Survey Guidelines and Support tool (NUPAS). The NUPAS assessment focused on six criteria: (1)Legal Structure, (2)Financial Management and Internal Control Systems, (3)Procurement Systems, (4)Human Resources Systems, (5)Project Performance Management and (6) Organizational Sustainability and the scores obtained were 87% for RBP+, 85% for ANSS and 76% for SWAA Burundi. With these scores the CSOs don't have deficiencies and if they have weaknesses, they are moderate and remediable.

Priority Health Domain Strategies

Progress Overview - Maternal and Newborn Health Strategy

Planned for Y2	Achievement and results	Comments
Conduct two six-day training sessions on EONC – train 30 providers from Karusi (15) and Muyinga(15) provinces	Achieved	
Conduct two, six-day training sessions on BEmONC for 30 providers (2 doctors and 28 nurses) from Kirundo province	Achieved 93%	26 providers trained
Conduct two, six-day training sessions on BEmONC for 30 providers (2 doctors and 28 nurses) from Karusi province	Achieved	
Conduct follow up supervision on BEmONC implementation in the four provinces		BEmONC supervision tool yet to be validated by the PNSR
Train 54 providers from nine hospitals in intervention on maternal death audits	Achieved	56 providers trained
Support monthly maternal death audits in 9 hospital		15 maternal death audit sessions conducted after training 56 health workers
Identify providers to be trained on neonatology	Achieved	
Conduct neonatology training for 24 nurses (four for each of six hospital)	Delayed	University Teaching Hospital trainers not available
Conduct post training supervision on neonatology		
Train and support three district hospitals on monthly blood collection drives	47 blood drive sessions conducted by Muyinga hospital	1,933 units of blood collected

To further enhance Burundi's health system capacity and contribute to the reduction of maternal and neonatal mortality, IHPB implemented activities in partnership with the National Reproductive Health Program (PNSR) which aims to strengthen provider capacity to deliver MNH services and increase access and quality of essential MNH. These included:

Trainee practicing on episiotomy reparation in station 3

- Two (2) sessions of six-day training sessions on sssential obstetric and neonatal care (EONC) for a total of 30 providers from Muyinga (15 providers) and Karusi (15 providers): the objective of the training was to strengthen health care providers' capacity in offering quality continuum of services before, during and after pregnancy. Organized in two parts, in the first part,

for two days participants followed theory topics (in class) related to antenatal care, safe delivery and post-natal care. The two day theory was followed by four days of practical sessions using standardized check list to become competent in offering services during the three periods (antenatal, delivery and postnatal). For the second part of the training, three stations were established: (1) for antenatal services where discussed focused antenatal care and PMTCT, (2) for safe delivery where delivery, active management of the third stage of labor (AMTSL) and newborn resuscitation (3) for post-natal services with focus on episiotomy, mother resuscitation and post-natal services.

- The project produced 280 BEmOC job aids including 10 algorithms and provided them to 28 health facilities with providers trained on BEmOC. The project also conducted supportive supervision for providers on MNH-related activities in 22 health facilities in Muyinga

- Four(4) sessions of six days training on Basic Emergency Obstetric and Neonatal Care (BEmONC) for a total 56 health providers from Kirundo (26) and Karusi (30. The sessions were conducted in Bujumbura at the National Institute of Public Health (INSP) and consisted of strengthening health providers' capacity at offering quality emergency obstetric care in their respective facilities. Seven signal interventions for BEmONC are defined and must be available to all women giving birth in order to address major causes of maternal and newborn mortality - (1) parenteral treatment of infection (antibiotics), (2) parenteral treatment of pre-eclampsia/eclampsia (anticonvulsants), (3) parenteral prevention and treatment of postpartum hemorrhage (uterotonic), (4) manual vacuum aspiration of retained products of conception, (5) vacuum assisted delivery, (6) manual removal of the placenta and (7) newborn resuscitation. Each training session includes:

A trainer performing the ventouse extraction

- In-service trainings, which include best practices in the management of labor, demonstration of key intervention on anatomic models and cases studies;
- Acquisition of competencies session where learners use standardized checklist to become competent in specific skills;
- Two five-day training sessions on maternal death audits were organized for 56 health care providers. The first session brought together 25 health care workers (8 female and 17 male) from Karusi and Muyinga provinces - 15 from 5 hospitals (2 hospitals in Karusi and 3 hospitals in Muyinga) and 11 health workers from BDS and BPS. The second, brought together 31 health care providers (10 female and 21 male) from Kirundo (2 hospitals) and Kayanza Provinces (3 hospitals). The training sessions focused on the following topics: (a) How to make pregnancy safe - analyze maternal deaths and complications; (b) Why analyze maternal deaths and obstetric complications; (c) Challenges and prospects of reducing maternal and neonatal mortality in Africa; (d) Methods of maternal health audits; (e) Reviewing severe maternal morbidity ("Near-Miss"); (f) Verbal Autopsies: Learning from the Death Review occurring in the community; (g) Confidential enquiries into maternal deaths; (h) Study of maternal deaths in health facilities; (i) Clinical audits; (j) Factors facilitating the implementation of audits; and (k) Development of action plans at hospitals;

- Fifteen (15) maternal death audits session were conducted under IHPB logistical and technical support with district hospitals of Giteranyi (4), Muyinga (2), Gashoho (2), Kayanza (2), Musema (2), Gahombo (2),

and Buhiga (1). The main causes of death identified were postpartum hemorrhage, uterine rupture due mostly to insufficient surveillance; and

- A total of 47 sessions of blood collection drives were conducted by the Muyinga hospital where 1,933 units of blood were collected from January to September 2015. The IHPB support consisted in logistic support when if needed. The Hospital is trying to conduct this activity by its own and ask for support from time to time. Blood collection sessions are regularly conducted by Muyinga hospital. 2 sessions supported but the hospital is conducting some sessions without IHPB support.

The main challenge in Y2 was the availability PNSR for joint supervision, the trainers on neonatology from the University Teaching Hospital for trainings on neonatology, the trainers on blood collection from National Center for Blood Transfusion (CNTS) for 2 hospitals of Kayanza and Kirundo. To overcome this, IHPB is working with PNSR to integrate all year 3 planned MNH activities in the work plan that PNSR will elaborate for 2016.

Progress Overview - Reproductive Health Strategy

Planned for Y2	Achievement and results	Comments
Conduct three 11-day training sessions of 45 providers on contraceptive technologies from Kirundo province	Achieved	
Conduct two 11-day training sessions of 30 providers on contraceptive technologies from Muyinga province	Achieved	33 trained
Identify health centers that can offer YFS	Achieved	13 health centers identified
Train 30 nurses providers on YFS	Achieved	35 trained.
Conduct post training supervision	Achieved	Two supportive supervision in 7 health Facility

In Y2, in partnership with the National Reproductive Health Program (PNSR) and provincial and district health bureaus, IHPB:

- Organized and conducted five 11-day training session on modern contraceptive technologies whereby 78 health care providers (45 male and 33 female) were trained: 45 from Kirundo and 33 from Muyinga province. The trainers came from the core of trainers set up by the PNSR. The training sessions were divided into two periods; the first period duration is 6 day and the trainers are focused on the theory and practicum on the anatomic model. During the second 5-day session, participants practiced in a health facility.

- 13 health centers that can offer Youth Friendly Services (YFS) were identified in Muyinga (4) and Kirundo (9) provinces by using the following criteria: (a) A public/faith based or local NGO-operated health center that can offer (a) BCC and communication on RH; (b) counseling and family planning methods; (c) prevention and treatment post abortion complication; (d) The consultation for menstrual disorders; (e) Counseling, prevention, diagnosis and treatment of STI; (f) ante natal and post-natal care; (g) Assisted delivery by skilled personnel in health care; (h) VCT and PMTCT; (i) Prevention and management of SGBV; (j) Vaccination against tetanus and HPV; and (k) pregnancy test.

- Organized two 5-day training sessions and trained 35 (23 male and 12 female) health workers from Kirundo (20c) and Muyinga (15) province on sexual and reproductive health of adolescents and young people. A team of five trainers from the MPHFA and the district level facilitated the training using the

PNSR manual – MANUEL DE FORMATION DES PRESTATAIRES DE SOINS EN SANTE SEXUELLE ET DE LA REPRODUCTION DES ADOLESCENTS ET DES JEUNES

- Conducted two post-training supervision visits on family planning in 7 health centers health centers of Kirundo provinces. During the supervision, the post training work plans were evaluated and the supervisors found that health facilities don't have equipment (example: gynecological which IHPB addressed by providing medical equipment to facilities.

Progress Overview - HIV/AIDS Strategy

Planned for Y2	Achievement and results	Comments
Support facility renovations to improve district and hospital functionality		Initiated renovation of the Emergency Unit and Laboratory Services of Muyinga Hospital
Support supervision and coordination activities	Achieved	158 health facilities supervised using SIMS. 9 coordination meetings organized out of 4 planned.
Train health care providers on HIV testing techniques	Achieved	48 out of 49 planned trained
Train trainers on the integration of RH/ HIV/PMTCT service	Achieved	38 out of 30 trainers planned trained
Train providers on the integration of RH/HIV/PMTCT services	Achieved	363 out of 212 planned trained
Train health providers on STI management	Achieved	252 out of 184 planned trained
Increase ART sites located in project intervention zone	Achieved	12 out of 15 planned new satellite sites established
Maintain equipment for HIV testing and PLHIV biological and immune- virological monitoring	Achieved	Maintenance contract is signed with Beckton Dickson Nairobi.
Through IKG support transportation of CD4 and DBS samples	Achieved	75 DBS transported to INSP out of 56 planned
Disseminate MOH-developed new HIV prevention and ART guidelines	Achieved	76 ART guides, 245 PMTCT guides, 70 PEP guides and 157 HTC SOP distributed
Monitor sharing of knowledge acquired during training sessions with other providers	Achieved	During different training sessions, participants share knowledge with their co-workers in feedback meeting.

In Y2 IHPB provided in-kind grants (IKGs) to the 12 BDS and nine district hospitals. These IKGs were used to support: (1) supervision visits and coordination meetings; (2) trainings of health providers on HIV testing techniques, HIV counseling, integration of RH/HIV/PMTCT services, and STI management; (3) operating expenses regarding office equipment and communication fees, including internet subscriptions; and (4) maintaining equipment for HIV testing and PLHIV biological and immuno-virological monitoring.

In collaboration with Health Provinces and District Bureaus of Karusi, Kayanza, Kirundo and Muyinga, IHPB:

- Supported rehabilitation of emergency room and laboratory service of the Muyinga district hospital. The works consisted in painting walls and tiling floors in order to meet standards of norms.

- Conducted supervision, using the new PEPFAR SIMS grid whereby 158 health facilities were visited: 28 in Karusi province, 15 in Kayanza province, 64 in Kirundo province and 51 in Muyinga province. Main observations are: lack of client monitoring tools; stock out of some HIV commodities; challenges in monitoring missed appointments for ARVs supply, cotrimoxazole or CD4 count every 6 months for some patients; and missing clinical and biological information in patients' records. To address the issues, appropriate and feasible solutions were proposed and began implementing by IHPB and partner facilities.

- In partnership with the National HIV/AIDS Control Program, IHPB organized various training sessions on HIV/AIDS-related themes with the objective to improve knowledge and strengthen health care provider capacities:

  (a) 5-day training on HIV testing techniques, using the "Directives nationales sur le dépistage du VIH au Burundi". A total of 48 lab technicians (31 male and 17 female) were trained on HIV rapid test and DBS (dried blood spots) sampling for HIV early diagnosis among infants using PCR technique. During the training session, participants had the opportunity to practice key steps in HIV diagnosis.
  (b) 5-day training on HIV counseling, using the "Module de formation sur le dépistage du VIH intégrant le dépistage à l'initiative du prestataire". 145 counselors (104 male and 41 female) were trained. The purpose was to strengthen the skills of the health providers in order to integrate HTC in their routine services and be able to conduct good counseling to different categories of clients in HTC in general population as well particular people namely: pregnant women, youth and adolescent, couple, sexual violence survivals, children, certain diseases like STI and TB.
  (c) 5-day training on STI management, using the **"**Guide de prise en charge syndromique des Infections Sexuellement Transmissibles au Burundi. 252 healthcare workers (156 male and 96 female) attended. The purpose of the trainings was to strengthen the capacities of the health providers in diagnostic and managing of STI with new algorithms.
  (d) 5-day training on ART services using "Directives nationales de traitement antiretroviral et de prévention de l'infection par le VIH au Burundi". 45 health care workers (24 male and 21) were trained on the new ART protocols.
  (e) Following a 5-day training of trainers whereby 38 (35 male and 3 female) were trained as trainers, 11 5-day training sessions on the integrated RH/ HIV/PMTCT service, using the "Manuel de référence pour la formation sur la prise en charge intégrée en matière de SR/VIH/PTME" were organized and 363 health workers (220 male and 143 female) were trained. The purpose of the training was to strengthen knowledge on linkage between SR and HIV/PMTCT so that they could offer quality integrated SR/HIV/PMTCT services.
- Supported mentoring and coaching health providers for ART initiating and follow-up in new accredited ART sites as well as transportation of DBS samples from health facilities to national laboratory (INSP). A total of 12 new ART sites were established and 75 samples has been transported from targeted provinces to INSP.

- Distributed MPHFA HIV guidelines and job aids to let HIV sites operate with standards: ART guides (76), PCR guides (245), PMTCT guides (245), PEP guides (70) and HTC SOP (157). The purpose is to let HIV sites operate with standards.

Progress Overview - Malaria Strategy

Planned for Y2	Achievement and results	Comments
Design and implement one-day provincial sensitization workshop on IPTp benefits and introduction and roll-out strategy in Kirundo, Gashoho and Gahombo health districts (234 participants)	Achieved	204 attended : 63 Muyinga (18F&44 M), 65 kirundo (15 F &50 M) and 76 in Kayanza (25F & 51M)
Multiply and disseminate 200 laminated copies of IPTp implementation guide	Achieved	179 health centers, 12 BDS and 9 hospitals received one copy of the guideline
Multiply and disseminate 200 algorithms on care for pregnant woman	Achieved	184 health centers and 16 district hospitals received one copy of the guideline
Conduct three, three day training sessions on IPTp (refocused ANC including IPTp) – train 83 nurses and 6 medical doctors from three health districts – Kirundo, Gashoho and Gahombo	Achieved	96 trained – 76 health providers and 20 as trainers
Conduct six three-day training sessions on IPTp (refocused ANC including IPTp) – train 80 nurses and 6 medical doctors from nine health districts of the provinces of Karusi, Kayanza, Kirundo and Muyinga contingent upon availability of SP	Achieved	179 [4] trained
Supportive supervision visits in HF to ensure quality of malaria prevention activities (e.g. counseling, acceptance rate, vital statistics) for pregnant women and children under five years (case management of malaria, diagnosis, ITN and ANC)	Achieved	18 HC supervised
Conduct three, four-day trainings of CHW on CCM of malaria (74 CHW) in Kirundo and Gashoho HD	Achieved	70 (68 from Kirundo HD and 2 from Gashoho HD) trained
Supply equipment of CCM of malaria for CHWs in Gahombo, Kirundo and Gashoho HD	Achieved	CCM of malaria kits supplied according to needs expressed by 3 CCM of malaria districts
Support monthly follow up meetings with CHW, in-charge nurses and HPTs on CCM of malaria	Achieved	3 follow up meetings held in each of the 3 CCM of malaria districts
Ensure monthly supportive supervision for CHWs (done by HPs and HPTs)	Achieved	About 44 CHWs per month in Kirundo, 16 in Gahombo, and 94 in Gashoho benefitted from supportive supervision on CCM of malaria at HH and HC level
Ensure quarterly supportive supervision for CHWs (by BDS and IHPB)	Achieved	2 quarterly supportive supervision conducted in each of the 3 CCM of malaria districts
Conduct three five-day training sessions for	Achieved	86 nurses trained

[4] HD supervisors and nurses from hospitals have not been taken in account in the Y2 WP. As IPTp is a new strategy in the national health policy of Burundi, it was important to train that category of health workers to ensure supervision and follow up of IPTp implementation

Planned for Y2	Achievement and results	Comments
80 nurses on guidelines for malaria community case management in Muyinga Province		
Conduct seven six-day training sessions for 120 microscopists/laboratories on correct malaria diagnosis	Achieved	127 microscopists trained
Support monthly technical meetings for information system on CCM of malaria at district level	Achieved	After receiving and analysis of monthly CCM of malaria reports, HD team and malaria technical officer met to clarify and improve the quality of CCM of malaria reporting
Support supportive supervision for facility case management	Achieved	18 HCs supervised
Develop key messages and leaflets on IPTp	Achieved	Key messages developed
Multiply and disseminate 500 copies of leaflets on IPTp to CHWs	Achieved	500 leaflets distributed

In Y2, in partnership with the National Malaria Control Program (PNILP) and in line with the 2014 Malaria Operational Plan (MOP), IHPB:

- Organized sensitization workshop on rolling-out Intermittent Preventive Treatment in pregnancy (IPTp) in 3 IHPB's provinces - Muyinga, Kirundo and Kayanza. The goal of the workshop was to inform and share information on rolling out IPTp as a new strategy of malaria prevention for pregnant women. In Muyinga province, this meeting gathered 63 participants (18 female and 44 male). In Kirundo Province, this sensitization workshop gathered 65 participants (15 female and 50 males). In Kayanza Province, 76 participants (25 female and 51 males) attended;
- Produced and dispatched 200 laminated copies of IPTp implementation guide to 179 health centers, 9 district hospitals and 12 health district bureaus;
- Produced and dispatched 200 algorithms on IPTp care for pregnant woman to 179 health centers, 9 district hospitals and 12 health district bureaus;
- Supported a three-day training session of trainers on IPTp –20 trainers (8 females and 12 males) including 6HD directors. The training was facilitated by 2 staff from NMCP and 1 from PNSR. At the end of this training session, health districts directors established the agenda to train health care workers in their respective districts;
- Trained 76 health care (47 male and 29 female) from three health districts: Gahombo (20), Kirundo (25), and Gashoho (31);
- Trained 179 health providers (110 male and 69 female) from 9 health districts on IPTp implementation: Giteranyi (23), Muyinga (31), Musema (20), Kayanza (20), Mukenke (12), Vumbi (14), Busoni (10), Buhiga (25), and Nyabikere (24);
- Conducted 3, four-day training sessions of 70 CHWs (31 male and 39 female) from Kirundo (68) and 2 new CHWs from Gashoho HD on CCM of malaria. 4 CHWs from Kirundo HD didn't attend because have fled to Rwanda. Nurses trained in 2014 on how to conduct and follow CCM of malaria carried out these trainings with the help of implementation guide and commodities from HC;
- Trained 54 pharmacy (25 male and 29 female) staff from Kirundo province as trainers on quantification, stock management, and inventory methods—who then trained 238 CHWs from Kirundo health district;

- Provide material and tools to 242 CHWs in Gahombo, 257 CHWs in Kirundo and 160 CHWs in Gashoho districts. To further support CCM of malaria implementation in Kirundo, Gashoho and Gahombo HD material and tools provided imply: registers, stocks cards, transfer books, supply books, umbrellas, bags, solar lamps, gloves and safety boxes as well as needed;

- Supported financially and technically the monthly CHW meetings to follow up CCM of malaria implementation attended by CHWs from Gahombo (232) CHWs), Gashoho (156 CHWs) and Kirundo (251 CHWs) health districts. These technical meetings focused on analysis of CHWs data reports, how to fill in the registers, revising the referral form and resolving challenges met by CHWs that include a shortage of RDTs, resulting in the referral of all malaria cases at health center;

- Supported technically monthly following up visits for CHWs done by health providers and health promotion technicians: To monitor the quality of malaria community activities, health promotion technicians and nurses carried out supervision visits within the community. A monthly average of 94 CHWs in Gashoho, 48 CHWs in Gahombo, 45 CHWs in Kirundo HD have benefited from this supervision visits;

- Conducted with BDS team 2 quarter joint supportive supervision visits within household level in CCM of malaria areas. 18 CHWs in Gashoho, 26 CHWs in Gahombo and 26 CHWs in Kirundo HD have been visited to ensure proper use and conservation of tools and material and implementation of malaria activities. With the help of the supervision tool, the supervision team observed that some CHWs forgot symptoms of severe malaria and don't refer correctly to health centers. The team found also that rapid diagnostic tests (RDTs) used by Gahombo CHWs are not adapted to be used within the community then returned those RDT to the health center and recommended to HPT to convene a meeting with all CHWs in order to ask them to give back those RDT at their HC;

- Trained 86 (39 male and 46 female) health workers on the 2012 New Guidelines of Malaria Case Management: nurses and health districts supervisors from Giteranyi (23), Muyinga (44), and Gashoho (19) participated. With the use of power point presentations made by MSH, NMCP staff and HD directors conducted these training sessions;

- Trained 127 (46 female and 81 male) microscopists on Correct Diagnosis of Malaria using microscopy and RDTs: Mukenke (9), Vumbi (13), Kirundo (17), Busoni (12), Gahombo (16), Muyinga (25), Giteranyi (18), and Gashoho (17). Material (planches identification des parasites du plasmodium) and technical modules have been used and distributed to participants;

- Supported 2 monthly technical meetings in Gahombo, Kirundo, and Gashoho HD. To improve the quality of malaria information generated by CHWs, IHPB in close collaboration with Kirundo, Gahombo and Gashoho HD held a meeting with nurses, supervisors and health promotion technicians to analyze and resolve issues on data collection at the community level and resolve problems on stock out of malaria commodities within the community;

- Conducted 3 join supportive supervision visits in 18 health centers. In collaboration with HD supervisors and NMCP staff: 6 HC in Kirundo HD (Gakana, Cumva, Kiri Rugasa, Ruhehe, Rukuramigabo), 3 HC in Gashoho HD (Gisabazuba, Kagari, CDS Camp Congolais), 3 HC in Giteranyi HD (Gahararo, Kidasha, Butihinda) and 6 in Gahombo HD (Mubogora, Ngoro, Rukago, Nzewe, Ceyerezi, Gakenke) have been supervised. These supervision visits of malaria activities were focused on availability and monitoring of malaria commodities and quality of clinical and parasitological diagnosis, including aspects on mobilization of community members on using preventive methods and seeking timely care

within health centers. In terms of malaria diagnosis, there still a big challenge for microscopists (non-qualified staff) to follow protocols to conduct a correct diagnosis of malaria;

- Developed key messages and leaflets on IPTp. Key IPTp messages in Kirundo have been validated by NMCP staff and IEC and pre-tested towards CHWs. These keys messages presented on leaflets will be used by CHWs in order to sensitize pregnant women to adopt IPTp-SP;
- Produced and disseminated 500 copies of leaflets to CHWs in Kirundo (257) and Busoni (236) HD.

Training of HD lab technicians in Mukenke and Gahombo

Progress Overview - Child Health Strategy

	Planned for Y2	Achievement and results	Comments
Improve clinical IMCI	Develop a simplified IMCI supervision form	Achieved	
	Sensitize BDS for integrating IMCI into routine supervision activities	Achieved	
	Train 36 health providers on clinical IMCI in Nyabikere health district (Karusi)	Achieved 81%	29 were trained
Improve nutrition services	Conduct five-day training of 32 health providers from Nyabikere health district on acute malnutrition management and ENA/IYCF	Postponed for implementation in Y3	The training was to follow the training of CHWs planned in April but it was done in September 2015

During year 2, IHPB in collaboration with the MPHFA:

- Developed a simplified IMCI supervision form and sensitized the BDS for integrating IMCI into routine supervision activities: a simplified form for clinical IMCI supervision was developed in June derived from the complex 30 pages-form used by the Ministry of Health and Fight against AIDS in the occasional sessions of supervision. The simplified from checks: the proportion of health care providers trained on IMCI, if the register is filled following the IMCI practices, if there is stock out of child medicines, the availability of essential material. The simplified form was communicated and distributed to the 6 BDS in Kayanza and Muyinga who accepted to integrate it into routine supervision, replacing the supervision of health facilities a national team using the 30-page form; the application of IMCI practices by health care providers was not effective because it was not in routine supervision by the BDS.

- Conducted a 5-day training session on clinical IMCI for 29 (9 female and 20 male) persons including 20 health care providers from Nyabikere health district, 4 medical doctors from the two hospitals of Karusi province, 4 staff from the health district bureaus among whom the medical responsible of Buhiga health district, and one staff from the province health office.

PPP initiatives

Due to changes in the leadership of LEO ECONET and occasioned by the change/transition of Managing Directors, in Y2, IHPB did not obtain handsets which were critical for the implementation of the two PPP initiatives with LEO ECONET – Malaria Free through High School Malaria Champions and Improving Communication and Reporting of Community Health Workers (CHWs). While the project was able to introduce the proposed public private partnership to Kirundo health and education department authorities, due to the lack of handsets, it did not implement the following activities: train high school champions; distribute handsets and signing of code of conduct; project launch; and train High School professors on Malaria; train across the three High Schools (Cumva, Kiyonza, and Nyamabuye).

Progress overview - Innovation Study

	Planned for Y2	Achievement and results	Comments
Innovation study: Pilot of Integration of Prevention of Mother-to-Child Transmission (PMTCT) and Early Infant Diagnosis (EID) of HIV into Routine Newborn and Child Health Care	Develop Scope of Work for Technical Advisory Group (TWG)	Achieved	
	Set up the TWG	Started	SOW submitted to the MPHFA. but TWG not in place due to the limited availability of the MPHFA staff
	Convene Technical Advisory Group meetings	Delayed	Limited availability of the MPHFA staff during this period caused the delay
	Meet with district and provincial stakeholders		
	Elaborate Protocol including data collection tools	Achieved	Protocol completed
	Submit protocol to FHI 360's PHSC	Achieved	
	Submit protocol to Burundian IRB		Will be submitted after approval by FHI 360"s PHSC
	Train district and health center staff on pilot study forms		Will be conducted after approval by Burundi IRB and obtaining Statistical Visa
	Begin study implementation		March 2016 is earliest implementation would start
	Begin elaboration of other two protocols		IHPB will make appropriate recommendations to USAID

On June 21, 2014, IHPB submitted a comprehensive Innovation Plan which was approved by USAID on July 25, 2014. The Innovation Plan included three concept notes with the potential for high impact improvements to facility and community services: (1) Emergency Triage Assessment and Treatment (ETAT) strategy to decrease the child mortality rate in hospitals; (2) Integrated Community Case Management (iCCM) to

decrease child mortality/increase early childhood disease management; and (3) Integration of PMTCT and EID into Routine Newborn and Child Health Care.

In Y2, it was envisioned that IHPB will implement a pilot study on integration of PMTCT and EID in routine newborn and child health care. Key Y2 achievements are:

- Developed a Scope of Work (SOW) for the Technical Advisory Group (TAG) and proposed to the MPHFA, staff who may be part of the TAG and requested for the Minister's decision to official appoint TAG members. The TAG will include experts from MPHFA, USAID, other stakeholders and IHPB and will be requested to follow closely the implementation of the study. The SOW spells out roles, composition and the meetings frequency.

- Developed and submitted study protocol to the Scientific Affairs Committee of FHI360. Upon approval by the FHI360's Scientific Affairs and protection of Human Subjects Committee, in Y3, before commencing piloting the study, IHPB will seek approval from the Burundi Ethics Committee and Ministry of Planning and Development's Burundi Institute of Statistics.

From all indications, given our experience on how long it takes to initiate a study, the earliest IHPB anticipates to start implementing the first study would be March 2016. Before starting to implement a study, the steps involved are:

1. Develop protocols and data collection tools: Of the three studies, only for the Integration of PMTCT and Early Infant Diagnosis did IHPB develop the protocol and data collection tools.
2. Initiate approval process: first, the protocol and related tools are submitted to FHI360's Office of International Research Ethics (OIRE) that determines whether it is a study that involves human subjects. For the PMTCT and Early Infant Diagnosis study, the protocol was submitted for review the week of October 18th.
3. Once a study is determined as research, it is reviewed by the Protection of Human Subject's Committee (PHSC). Approval by the PHSC takes between three – six weeks.
4. Once approved by the PHSC, after translation to French, the protocol is submitted to the Burundi Ethics Committee. Review and approval by the Ethics committee might take four to six weeks.
5. Once approved by the Ethics Board, it is submitted to ISTEEBU for Statistical Visa. This might take any time between four to six weeks.

Progress overview - Learning, Documentation and Dissemination

Planned for Y2	Achievement and results	Comments
Analyze unmet needs for context-specific knowledge gaps and evidence gaps vs. potential Y2 learning opportunities and project resources		Learning priorities identified. Analysis of data from FABs provided insights to opportunities
Pursue selected Y2 learning priorities		Learning priorities identified will be pursued in Y3
Means to increase project staff awareness and use of data and knowledge incorporated into practice (ex: dedicated sessions for data presentation and discussion staff and team meetings)		Staff fully participated in data analysis and interpretation including generating relevant reports.
Expand project learning into and disseminate briefs		With FAB analysis and reports available, this activity will be fully pursued in Y3

Planned for Y2	Achievement and results	Comments
Draft and submit at least 1 abstract to ICASA 2015		Activity affected by departure of Communication and Documentation Officer
Convene scientific/technical writing workshops for IHPB and local partner staff, as resources allow		Due to prevailing circumstances, activity was not implemented in Y2
Participate in FHI360 Strategic Information training workshop	Achieved	2 staff attended
System/practices developed, tested and refined to share regional and global knowledge with project staff and incorporate into program		IHPB Reproductive Health Specialist attended the Implementing Best Practices in Family Planning Workshop
Identify and begin developing potential Y3 learning opportunities, priorities and actions	Achieved	Y3 Work Plan details potential priorities and topics
Establish and update project resource library		Activity affected by departure of Communication and Documentation Officer

IHPB presents critical opportunities for learning for the benefit of local partners and institutions and international health and development disciplines more broadly. The focus of IHPB's learning, documentation and dissemination will be to continue to document and disseminate information regarding IHPB project implementation and achievements. Key Y2 achievements include:

- Identified a number a number of potential learning opportunities that cut across Sub-CLINs, program and technical areas. However, due to the short nine-month period of the second year, coupled with the ongoing situation in the country and departure of the Communication and Documentation Officer, Y2 learning priorities were not fully pursued.
- Introduced the "IHPB News", a newsletter that presents and summarizes key ongoing activities - February 2015 issues was dedicated to US Congress Staffers visit IHPB; two March 2015 issues were on the US Ambassador to Burundi's visit to Community Health Workers delivering community case management of malaria in Gashoho and over forty nurses trained in basic emergency obstetric and newborn care. The April 2015 issue was on intermittent preventive treatment of malaria in pregnancy.
- IHPB Reproductive Health Specialist attended the Implementing Best Practices in Family Planning Workshop held in Addis Ababa (June 14 to 19, 2015) where he made a presentation on integration of family planning into maternal and child health services to reduce missed opportunities and improve the quality of services.

Progress overview for Program Monitoring and Evaluation

Planned for Y2	Achievement and results	Comments
Participate in DATIM training	Achieved	9 M&E officers trained on DATIM
Execute DATIM FY 15 planning	Achieved	
Contribute to PEPFAR semi-annual report and quarterly reports	Achieved	
Convene internal M&E workshop		Planned for implementation in October 2015
Participate in PBF validation meetings	Achieved	

During the reporting period, IHPB implemented planned and routine Project Monitoring and Evaluation activities:

(a) Within the framework of IHPB staff capacity building, 9 M&E officers attended a 3-day (May 25-27, 2015) training on DATIM and a 2-day (May 28-29, 2015) training on Data Quality Assurance (DQA);
(b) IHPB finalized and submitted the PEPFAR Semi-Annual Report 2015 (October 2014 to March 2015) and the April-June 2015 using the new web-based PEPFAR Planning and Reporting System DATIM (Data for Accountability, Transparency and Impact);
(c) IHPB developed the Kirundo OVC database after inclusion of the field officers' feed-back and trained 5 individuals (2 IHPB M&E field officers and 3 RBP+ staff) the use of updated OVC reporting tools and the OVC database;
(d) M&E Field Officers maintained routine data quality assurance through reports review and feed-back on the occasion of PBF monthly data validation meetings at the provincial level.

In the framework of partnerships, IHPB M&E officers attended various worships and meetings organized by MPHFA or other USG implementers:

(a) Senior M&E Advisor represented IHPB at a meeting organized by the National Program for AIDS/STIs Control for PEPFAR funded partners for the Fast Track (July 22, 2015);
(b) All IHPB M&E team (10) attended training on GESIS-VIH, a HIV/AIDS database developed by the National Program for AIDS control in partnership with the Department of National Health Information System and Measure Evaluation for health districts (August 27-28, September 1-2, 2015);
(c) M&E Senior Advisor and Data Manager attended a meeting organized by PEPFAR M&E Specialist for implementing partners M&E staff (Sept 25, 2015). The goal of the meeting was to discuss opportunities to improve the reporting system;
(d) Muyinga M&E technical Officer attended a workshop organized by Engender Health, BRAVI Project whose topic was the referral and reporting system of GV cases.

Project Management

Planned for Y2	Achievement and results	Comments
Upon approval by USAID, establish sub-offices in Karusi and Kayanza	Achieved	
Recruit and post staff as necessary	Achieved	
Convene quarterly planning and review meetings with partners	Achieved	
Bujumbura-based staff conduct support visits to sub-offices	Achieved	
Hold regular staff planning and management meetings	Achieved	
Develop Y2 workplan, present to MPHFA and partners, and submit to USAID	Achieved	
Submit monthly, quarterly and annual reports to USAID	Achieved	
Submit Y3 work plan	Achieved	
Participate in collaboration, coordination and partnership building meetings at national and field office levels	Achieved	

IHPB's management approach emphasizes open communication, transparency, costs efficiency, local ownership and collaboration and coordination with other programs and partners. Under the leadership of the Chief of Party (COP), the project is led by a six-member Senior Leadership Team (SLT) comprised of the COP; Deputy COP; Associate Director Finance & Administration (AD FA); Senior Technical Advisor Health Systems Strengthening (STA HSS); Senior Technical Advisor Monitoring and Evaluation (STA M&E); and Integrated Services Advisor. Key Y2 achievements are:

- Established fully functional sub-offices in Karusi and Kayanza provinces – these offices will further support and accelerate implementation of field activities with a stronger mandate to coordinate all assistance mechanisms of IHPB in the geographical area.
- Senior staff including the COP, DCOP and other Senior Leadership Team members conducted support supervision visits while key project activities were underway - trainings on CCM Malaria, QI/QA and integration, strengthening capacity of community structures, basic emergency and neonatal, modern contraceptive technology, building capacity of civil society organizations and other trainings. Key visits included: US Senate and House of Representatives Staffers visit (February 18, 2015) to Muyinga with the objective to have a picture of maternal and child health activities being implemented with the support of USAID in Burundi; and US Ambassador's visit (March 2015) to a CHW who treat malaria at the community level in Gashoho Health District.
- Under the leadership of the Chief of Party (COP), the six-member Senior Leadership Team (SLT) (COP; Deputy COP; Associate Director Finance & Administration (AD FA); Senior Technical Advisor Health Systems Strengthening (STA HSS); Senior Technical Advisor Monitoring and Evaluation (STA M&E); and Integrated Services Advisor) held regular weekly (on Mondays) meetings to make strategic decisions and monitoring program implementation including coordinating with USAID, GOB entities and other USG partners. Under the leadership of a Field Office Manager, technical teams also held regular meetings with their respective staff and in their respective offices.

- Submitted a nine-month Year 2 work plan (December 23, 2014 to September 30, 2015), which after incorporating comments and suggestions from USAID was re-submitted and approved on March 16, 2015.
- Submitted first annual (23 December – 22 December 2014) report, nine monthly progress reports and two quarterly (January to March and April – June) reports on time. The monthly and quarterly reports present achievements and challenges during the report period. In addition, IHPB developed and submitted the PEPFAR Semi Annual Performance Report (SAPR) into DATIM (Data for Accountability, Transparency and Impact) interface, and hosted the SAPR review meeting organized by the PEPFAR team to partners (June 16, 2015).
- Fostered collaboration and coordination with USG-funded projects and organizations that include Management Sciences for Health (planning to train health promotion technicians as trainers on supply chain management), Engender Health (shared job aids for GBV case management), Catholic Relief Services (participated in the official launching of the AMASHIGA Project and shared findings of IHPB gender assessment).
- Other management activities: These included: (a) Participation (March 7 to 21, 2015) by the Associate Director for Finance and Administration and Contracts and Grants Officer in a workshop on Grants Management and Administration Training, Finances Training organized by FHI360 in South Africa . (b) Organized the US Senate and House of Representatives Staffers Visit to IHPB Sites:

Problems Encountered/Solved or Outstanding:

Achievements registered in Y2 can be attributed to the close working relationships with the central and peripheral structures of the MPHFA; quality and timely technical assistance from IHPB home office staff; and timely response to IHPB requests by USAID. However, in achieving the planned activities, IHPB encountered challenges that include:

- Unavailability of critical partners - while training on clinical IMCI, on-the-job training on blood collection techniques, acute malnutrition management, and training providers on SGBV case management were planned, could not take place due to the unavailability of National Center for Blood Transfusion (CNTS), the National Food and Nutrition Program (PRONIANUT), and Seruka Center trainers.
- Planned STTA did not happen because of the travel ban on Burundi.
- Delays in procuring equipment due the lack of hard currency by suppliers.
- Lack of local capacity and consultants for SBCC materials development – consultant was not able deliver as planned resulting in cancellation of contract. For one consultant, IHPB had to offer additional training and guidance.
- Stock out of reagents for early infant diagnosis (EID).
- Decentralization of ART task shifting is not yet effective even though the MPHFA gave clear guidelines.
- Public Private Partnership initiatives could not be successfully implemented due the current business environment.
- Long process and delays in obtaining approvals from FHI 360's Protection of Human Subjects Committee and local Burundi Ethics Board and ISTEEBU resulting in delays starting planned innovation studies and formative and baseline assessments.

Annex I: Success Story

Title: How the US Ambassador's visit impacted my life as Community Health Worker
Sub-title: 'Being a CHW has been the biggest achievement of my life'

Francine Nijimbere, 34, is a Community Health Worker (CHW) living with her husband and three children in Shambusha, a village located in Gashoho commune, Muyinga Province. Her two daughters, who are respectively 19 and 17, are studying in Bujumbura and Ngozi while his youngest son, 14 just started high school and is living with his parents. Francine is an active CHW since 2011. She dropped from school in 7th grade due to civil war in Burundi. She had never hoped she could one day be able to treat malaria in her community. Passionate about her work, Francine proudly highlights one of her best experience: 'I am the first CHW to have been honored with a visit by the US ambassador to Burundi Ms. Dawn Liberi at my house'.

Malaria is a major public health problem in Burundi responsible for up to 60% of all outpatient visits and up to 50% of deaths in health facilities among children under five years. Gashoho is among health districts with highest risk for transmission and burden of malarial disease. Thanks to USAID fund, the Integrated Health Project in Burundi (IHPB) works to reduce child mortality related to malaria through the Community Case Management of Malaria (CCMM). This strategy promotes the early recognition, prompt diagnostic testing and appropriate treatment of malaria among children under five years of age in the home or community.

Francine has been trained and received material for malaria treatment and prevention. She treats up to five children a week. '*I did not do medical studies or have any background in health sciences; but I always felt a call to help others. I am lucky to share the vision with my husband, he values and encourages me in my work'* indicates Francine.
Her daily activities include treating malaria for children under five and helping women with health issues such as reproductive health, neonatal care, healthy behaviors and HIV. In parallel, she owns a small restaurant where she serves food to health providers at night shifts. '*Although in the beginning my community did not believe in my ability to treat malaria; whenever a child presents symptoms of malaria they come to me for help and if it is a serious case I guide them to where they can find assistance. My neighbors do not need to travel long distances anymore'* declares Francine.

On March 5th 2015, the US ambassador to Burundi, Ms. Dawn Liberi paid her a visit. '*I was elated, it felt good to see that the ambassador was carefully following my presentation on the CCMM process and being congratulated and applauded by her after I talked about my work was enjoyable*' recalls Francine. That was the first time a high level official visited a CHW in Gashoho. The privileged CHW claims to have noticed a significant change after the visit. People trust her more and feel encouraged to bring their children to be checked. 'The *number of children I treat has now increased, it went from 10 to 20 children a month*' says Francine.

IHPB IHPB's main objective is to improve the health status of assisted populations in twelve health districts located in the provinces of Karusi, Kayanza, Kirundo and Muyinga.

Francine encourages all her passionate fellow CHWs to pursue their work even if they are not paid for it. It is a valuable commitment to improve children's health condition in Gashoho. 'Our motivation should lie in the results we see in our communities' concludes Francine.

Annex II: STTA and other visitors to IHPB

Name	Title	Dates	Purpose
Gina Etheredge	Technical Advisor (M&E) FHI 360	February 18, 2015 March 11, 2015	Provide TA for household survey data collector training, pre-testing, and implementation
Juan Manuel Urutia	PPP/Private Sector Health Specialist Panagora	April 19-28, 2015	Development of new PPP initiatives, implementation of negotiated PPPs, and building capacity among the IHPB team and most specifically, the PPP team.

Annex III: Summary of Facility Qualitative Assessment and Service Availability and Readiness Assessment Findings

1. Summary of Key Findings: Facility Quality Assessment

Management of Health facilities (FOSAs)

- 53% of facility managers have been in their position for less than 2 years, indicating a high rate of turn over.
- Only 47% of facility managers have received a copy of their job description.
- The availability of trained service providers in sufficient number remains the main human resource issue mentioned by 74% of facility managers.
- The technical managers of health care were available in 5 of 9 districts hospitals. The four district hospitals who don`t have a technical manager of health care are Buhiga, Kayanza, Gahombo and Kirundo.

Trainings of health facility staff

- The most frequent training needs identified by managers include maternal, neonatal and child health (80%) and HIV (76%).
- Most facility managers have been trained in HIV care (62%), but less than 20% have been in basic and comprehensive emergency obstetric and newborn care.
- A small proportion of managers reported that are trained in comprehensive emergency obstetric and new born care (9%), basic emergency obstetric and neonatal care (18%), RH/HIV integration (27%), refocused ANC (22%).
- Less than 40% of managers are trained in drug /supplies management and data management.
- Most managers (75%) say that trainees share feedback with their colleagues after training.
- 66 % of facility managers do track the staffs who have attended training programs.
- 47% of facility managers identify the lack of post-training follow up support as a major issue.

Quality improvement processes at facility level

- 40 % of facilities received training on a PDSA-based QI model, more than any other model.
- For 64% of managers, a heavy workload limits the capacity and time of the staff to conduct QI activities.

Integrated delivery of services in facilities

a) **Multiple services provided to a patient by the same provider during the same consultation.**

- Refocused ANC consultation is the main opportunity where multiple services are provided to a client at the same time, followed by HIV, neonatal and curative care services. Integrated delivery seems lower for clients of family planning services.
- Not surprisingly, a limited workforce faces issues of heavy/additional workload (60%) to be able to deliver multiple services, while clients experience longer waiting time (68%);

b) **Multiple Services clients can access from different providers in the same visit through internal referral.**

- HIV testing is most frequently (93%) integrated to curative care through internal referrals to another provider in the same facility, whereas nutrition services are less likely to be offered (47%).
- The most reported challenges are similar to the first type of integration: The patient spends more time in the facility (76%) and there are not enough service providers to respond to the needs (67%).

Orientation training of service providers in FOSAs

- Health providers received orientation training, mainly from their Health Center Manager (63%), 10% by hospital Director or from their colleagues (29%).However 31 providers received twice an

orientation from different people. So, orientation training to learn about specific procedures is done less often in district hospitals (10%) than in health centers (63%).

Availability and quality of services

- Many factors affect the availability and quality of facility-based services, the most frequently reported y managers are: (i) shortage of qualified staff (76%), (ii) insufficient space in facility building/ rooms (64%), (iii) untrained personnel (62%), (iv) lack of materials and equipment (60%), and (v) insufficient financial resources (49%).

Supportive supervision of service providers

- 68% of service providers report that they receive monthly supervision visits, while 17% are supervised quarterly by the district health management team.
- Supervision visits are mostly perceived by the service providers as being supportive, although only 67% say that they are given a positive reinforcement.

Referral of patients

- Health providers refer patients mainly to their own facility through internal reference (93%), then to the district hospital (77%) and fewer to HC (37%) and ASC (23%).
- 77% of service providers in facilities receive referrals from ASCs.
- The main reported challenges in confirming completion of referrals in health district hospitals are respectively, lack of transport means (61%); appropriate referral tools not available (8%).
- The main mechanism used by 53 % of service providers to identify clients referred by CHW is a referral form with a code while 15 % reported that there is not any documentation.
- Clients referred face the issue of transport to the health facility (cited by 82% of service providers).

Client Follow-Up and Barriers to Utilization of Services

- Challenges for clients' use of services and follow-up appointment most often reported are the same: long travel distance to the facility and long wait time.
- Most service providers have a system to follow up with clients, which relies on paper-based information systems and the CHWs.
- Challenges faced by individuals in accessing services as reported by 69% of CHW, is the cost of drugs are too expensive for patients.

Recording client information

- 76% of service providers in FOSAs record patients' information in both registers and patient`s files for outpatients services.
- 58% of service providers in FOSAs record patients' information in both registers and patient`s files for inpatients services.
- Service providers in FOSAs face two main issues with the recording of patient information: with lack of time due to the load of work and user-friendliness of the registers themselves.
- 33% of CHWs have received no data collection tools and 29% lack the registers.

Work environment of FOSAs staff and CHWs

- A majority of FOSA-based service providers express satisfaction about their working relationships with colleagues, but express dissatisfaction about the load of work and the lack of resources.
- A minority of CHWs (40%) received a copy of their job descriptions, however, almost all CHWs (90%) received an orientation training within 6 months before this assessment whereas 98 % received support through meetings and supervision visits.
- Most CHWs (60 %) expressed the needs for work wear, means of transport, communication and financial incentives.

Commodities/medicines and equipment at the CHW level

Availability of commodities and medicines is a serious issue for CHWs:

- Only 58% of CHWs have regular supplies of male condoms and only 36% of female condoms whereas 14% have regular supplies of contraceptive pills and only 15% of ITNs.
- The vast majority of CHWS (78%) do not receive the malaria rapid test or anti-malarial drugs.
- Almost no CHW receive Zinc (95%) or SRO (99%), deworming tablets ((97%) and pneumonia drugs (99%).
- CHWs face a variety of challenges to avoid stock outs, most of them not under their control: No box to keep medicines and commodities (56%), not enough training given (53%) and problems of transportation (50%).

Services provided by CHWs

CHWs deliver mainly information, education, and sensitization services, distribute some commodities such as condoms, refer patients to facilities and deliver very few clinical services:

- Most FP services delivered by CHWs focus on condom distribution and referring women to the health center.
- All CHWs provide sensitization and awareness messages regarding ANC, delivery, HIV, maternal and newborn health services issues and refer patients to FOSAs.
  HIV services delivered by CHWS focus on HIV counseling, referring for testing and support of adherence to ART.
  CHWs screen children for malnutrition and refer them for nutrition rehabilitation within the community or at the health center.
  Most CHWs (61%) experience issues of tranport to be able to serve all households

2. Summary of Key Findings: Service Availability and Readiness Assessment

IHPB conducted a Service Availability and Readiness Assessment (SARA) to determine the availability of core and expanded packages of essential integrated health services offered by health facilities, both at in the facility and community levels, as well as to identify the extent of and opportunities for integration; the level of qualified staff to provide health services; the level of human resources and commodities management support systems available to assure quality of services; the level of infrastructural resources available to assure quality of services; the flow of information to and from the district and community levels; and the functionality of the facilities' COSAs.

This assessment was conducted in all 173 health facilities, comprising 164 health centers and nine district hospitals, located in the four project-supported provinces. Data were collected through interviews with health facility managers or their designee, health care providers, health promotion technicians (TPS), and COSA (Health Committee) members. This assessment was submitted and approved by Burundi's Comité National d'Ethique de la Recherche and FHI 360's Office of International Research Ethics.

FAMILY PLANNING

Service Availability | National guidelines state that all health facilities provide modern methods of contraception; however FP methods are available in less than 80% of health centers in Kayanza, Gahombo, Kirundo, and Gashoho districts, and Gahombo and Kirundo district hospitals do not provide any FP services. Almost all of the health centers and all district hospitals that provide FP services integrate HCT, IMCI, post-natal care, malaria, and STI into FP services. GBV screening is not yet integrated into FP in about half of facilities. Almost all (96%) health centers have CHWs that conduct FP awareness in communities and counseling/provision of condoms and counseling on other modern methods of contraception.

Service Readiness | In the three months prior to the survey, each modern method of contraception had a stock out in about one-quarter of health centers. Muyinga and Giteranyi district hospitals were the only district hospitals that did not experience any stock out of any of the modern contraceptive methods in the three months prior to the survey. In general, less than half of health centers and district hospitals had available FP guidelines and about 60% had available the FP verification list/checklist. The proportion of health centers that have at least one health provider trained in FP counseling/provision is 80%, in emergency

contraceptives is 72% and in adolescent sexual and reproductive health (SRH) is 51%. Eight of nine district hospitals have at least one health provider trained in FP counseling/provision and emergency contraceptives while six have a provider trained in adolescent in SRH.

Recommendations

- Availability of modern FP methods need to be up to all health centers and hospitals.
- The lack of GBV screening in FP services is a missed opportunity, and health facilities should identify ways to routinely integrate GBV screening during FP appointments.
- In the few health centers that do not offer FP awareness in communities, CHWs should be trained to conduct awareness raising and counseling on modern FP methods.
- Consistent stock of modern FP methods is necessary, and therefore efforts should be made to identify the root causes of stock out of medicines, including contraceptives.
- Health facilities should identify and track which staff have not yet received FP and SRH training, and coordinate with district health management teams to ensure that all staff providing services have been trained and perform to technical quality standards.

MATERNAL HEALTH

Service Availability | ANC services are offered at all health centers with services almost universally comprising HCT, tetnus toxoid immunization, ITN distribution, deworming, screening for hypertension and STI screening. Intermittent preventive treatment of malaria during pregnancy (IPTp) is a new strategy that is not yet implemented in health facilities. ANC service delivery integrates FP and WASH counseling in 91% of health centers and IMCI in 90% of health centers. GBV screening is not well integrated. Almost all (98%) health centers have CHWs that conduct ANC and post-natal awareness in communities and 90% support retention in ANC. About half of health centers have CHWs that provide tetanus toxoid immunization and iron/folate supplements in the community.

About half of health centers do not offer oxytocics, anticonvulsants, and antibiotics, essential components of Basic Emergency Obstetric Care (bEmOC) which should be available at all health centers. Eight of the nine district hospitals offer the complete package of Comprehensive Emergency Obstetric Care (cEmOC) services – Giteranyi district hospital does not offer assisted vaginal delivery and caesarean section. Most health facilities integrate HCT, FP counseling, and STI screening into maternity services. Among health centers, about two-thirds integrate child immunization and nutrition assessment and counseling services. Maternity services are limited at the community level with only 60% of health centers having CHWs that conduct counseling on essential newborn care, 26% screening for maternal hemorrhage, and 4% conducting neonatal resuscitation.

Service Readiness | In the three months prior to the survey, health centers experienced a range of stock outs of ANC and/or delivery medicines – 63% of health centers had a stock out of oxytocin. There were no district hospitals that did not experience a stock out in any delivery medicines in the three months prior to the survey, and Musema, Gahombo and Giteranyi district hospitals experienced a stock out of every medicine. ANC and maternity guidelines were available in less than one-third of health centers and hospitals; however almost all facilities had available the maternity partogram. Most health centers had available materials and equipment for ANC, delivery, post-natal care; however some materials such as a delivery table (42%) and box deliveries (18%) were lacking. At the district hospital level, about half of facilities were lacking equipment needed for complex deliveries. Only half of health facilities have at least one provider trained in BEmOC and only one-third have staff trained in IMPAC. Six of nine district hospitals have at least one provider trained in CEmOC and five in IMPAC.

Recommendations

- Availability of IPTp needs to be up to all health facilities, particularly health centers where ANC is mainly provided.
- Integration of IMCI into ANC could be scaled up to the remaining 10% of health centers where it is not occurring yet.
- The lack of GBV screening in ANC services is a missed opportunity, and health facilities should identify ways to routinely integrate GBV screening during ANC appointments.

- BEmOC and CEmOC should be completely scaled up to all health centers and district hospitals, respectively.
- In the few health centers that do not offer ANC awareness in communities, CHWs should be trained to conduct awareness raising and support retention in ANC, including delivery in a health center. Efforts should be made to scale up provision of tetanus toxoid immunization and iron/folate supplements in the 50% of health centers where this service is not offered. CHW roles can further be expanded to conduct counseling on newborn care to integrate ANC and maternity awareness raising.
- Consistent stock of maternal health medicines is necessary, and therefore efforts should be made to identify the root causes of stock out of medicines.
- Health centers and district hospitals are not fully equipped with the necessary equipment to efficiently provide quality services – these facilities should be provided with the equipment.
- Health facilities should identify and track which staff have not yet received BEmOC, IMPAC, and/or CEmOC training, and coordinate with district health management teams to ensure that all staff providing services have been trained and perform to technical quality standards.

Child Health

Service Availability | All health centers offer immunization services and 84% offer growth monitoring. According to national guidelines, health centers should offer Integrated Management of Childhood Illnesses (IMCI); however treatment of pneumonia and diagnosis/treatment of malnutrition have not scaled up to all sites. Ninety percent or more of health centers integrate post-natal care, ITN distribution, growth monitoring, and FP counseling into immunization services, and 74% offer follow up of HIV-positive mothers. WASH counseling, growth monitoring, immunizations, FP counseling, HCT, and pregnancy testing of mothers is well-integrated into child curative services in health centers and district hospitals (excepting growth monitoring and immunizations in hospitals). At the community level, most health centers have CHWs that conduct verification/retrieval for immunizations, vitamin A awareness, and counseling/provision of ORS, growth monitoring. Less than two-thirds of health centers have CHWs that implement community-based management of acute malnutrition (CMAM), IMCI, or provision of deworming tablets.

Service Readiness | Stock of child health medicines, including vaccines, is mostly consistent. 97% of health centers maintained consistent stock of oral rehydration salts in the three months prior to the survey and 80% of health center maintained stock of vitamin A. Converse to this however, only 21% of health centers maintained stock of Plump Nut. About two-thirds of health centers had available IMCI guidelines and half had available vaccination guidelines. 91% of health centers had available vaccine carriers and 86% had icepacks, necessary equipment to maintain the cold chain for immunizations. About three-quarters of health centers had available equipment needed to conduct growth monitoring. About three-quarters of health centers and eight district hospitals have at least one provider trained in IMCI.

Recommendations

- IMCI needs to be fully scaled up to include growth monitoring and treatment of pneumonia and diagnosis/treatment of malnutrition in health centers where it is currently lacking.
- There are a few remaining health centers where post-natal care, ITN distribution and FP counseling should be integrated into immunization services. Furthermore, health centers should consider follow up of HIV positive mothers during immunization services and maintain referrals to PMTCT and/or ART.
- Provision of CMAM, IMCI and provision of deworming tablets by CHWs should be scaled up to all health centers.
- Health facilities should identify and track which staff have not yet received IMCI training, and coordinate with district health management teams to ensure that all staff providing services have been trained and perform to technical quality standards.

HIV/AIDS

Service Availability | For HIV prevention services, all health facilities offer HIV counseling and testing services, however voluntary medical male circumcision (VMMC)are only available at 12% of health centers and seven district hospitals. About 80% of health centers provide GBV screening, condom distribution, WASH counseling and VMMC counseling integrated into HIV prevention services and only half of health centers

integrate STI screening and FP counseling; these services are integrated into HIV prevention services in almost all district hospitals. Prevention of mother-to-child transmission of HIV (PMTCT) services are not available at 5% of health centers and Gashoho and Giteranyi district hospitals (with limited availability at Gahombo district hospitals which only offers ARV prophylaxis). ART and care and support services have only scaled up to about one-quarter of health centers across districts and are currently lacking at Gahombo, Gashoho and Giteranyi district hospitals. Almost all health centers have CHWs that conduct HIV/AIDS/STI awareness (97%) and provide condoms (93%). PMTCT retention support, ART retention/adherence support, prevention with positives, and home-based care is limited at the community level with less than half of health centers offering these services.

Service Readiness | Stock out in first line of antiretroviral therapy medicines varied between district hospitals. Kirundo and Muyinga district hospitals had consistent stock of at least nine of the 11 ARVs. In contrast, Kayanza and Musema only had consistent stock in three of the 11 ARVs. About half of health centers and district hospitals had available national HIV testing guidelines and 70% of health centers and eight of nine district hospitals had available the HIV testing algorithm. 62% of health centers and eight of nine district hospitals had available the national guidelines on PMTCT. Most health centers have at last one health provider trained in HCT (90%) and PMTCT (89%). All the nine district hospitals have at least one health provider trained in HCT, prescription of ART, provision of ART, and ART management. Eight district hospitals have at least one provider trained in PMTCT and HIV care and support

Recommendations

- Availability of VMMC should be scaled up to all district hospitals and health centers that are ready to provide the service.
- Integration of GBV screening, STI screening and treatment, and FP counseling should be scaled up to the remaining 5% of health centers and Gashoho and Giteranyi district hospitals, where services are not yet available.
- PMTCT should be scaled up to all health centers and district hospitals where not currently available.
- ART services should be scaled up to Gahombo, Gashoho and Giteranyi district hospitals and to additional health centers that are ready to provide the service.
- PMTCT retention support, ART retention/adherence support, prevention with positives, and home-based care services should be scaled up at the community level through CHWs.
- Consistent stock of ARVs is necessary to ensure adherence and retention in ART, and therefore efforts should be made to identify the root causes of stock out of medicines.
- Health centers and district hospitals are not fully equipped with the necessary equipment to efficiently provide quality services – these facilities should be provided with the equipment.

MALARIA

Service Availability | All health centers and district hospitals treat Malaria with microscopy being the primary diagnostic tool. Rapid diagnostic tests are available in 85% of health centers and 4 of 9 district hospitals. Malaria prevention and HCT are integrated into Malaria services in most health facilities – however, Kirundo and Mukenke district hospitals report no integration into Malaria services. Nutrition assessment, counseling and support (NACS) are integrated in Malaria services in about 60% of all facilities. All health centers have CHWs that conduct malaria prevention awareness, however only about one-third distribute ITNs, use RDTs for malaria diagnosis, and/or counsel on IPTp for pregnant women. Almost half of health centers have CHWs that counsel on ACT for treatment of malaria.

Service Readiness | In general, malaria medicines were consistently available over 80% of health centers. In district hospitals, Quinine injections and Quinine tablets were consistently available in the three months prior to the survey in almost in all the district hospitals while stock of Artesunate-amodiaquin tablets was not consistent in many district hospitals. Ninety percent of health centers and six of nine district hospitals had available the national malaria treatment guidelines. About three-quarters of health centers and eight of nine district hospitals have at least one health provider trained in diagnosing malaria and prescribing treatment.

Recommendations

- Where feasible, use of RDTs should be scaled up to enable quicker diagnosis of malaria.

- Health facilities may consider scaling up Integration of NACS where it is not yet integrated.
- The lack of GBV screening in ANC services is a missed opportunity, and health facilities should identify ways to routinely integrate GBV screening during ANC appointments.
- Community level use RDTs for malaria diagnosis and counseling on IPTp for pregnant women should be scaled up through CHWs.
- Consistent stock of malaria medicines is necessary, and therefore efforts should be made to identify the root causes of stock out of medicines.
- Health centers and district hospitals are not fully equipped with the necessary equipment to efficiently provide quality services – these facilities should be provided with the equipment.
- Health facilities should identify and track which staff have not yet received malaria diagnosis and treatment training, and coordinate with district health management teams to ensure that all staff providing services have been trained and perform to technical quality standards.

GBV

Service Availability | Availability of various GBV services is lacking in two-thirds of health centers, and forensic evidence collection and clinical care for GBV survivors only available at 21% and 16% of health centers respectively. Mukenke and Giteranyi district hospitals do not offering any GBV services. Buhiga and Muyinga district hospitals do not provide forensic evidence collection, which should be available for comprehensive GBV services. Half of health centers have CHWs that provide GBV care awareness and/or referrals for GBV survivors.

Recommendations

- Where possible, GBV screening should be integrated into other existing services such as HCT and ANC.
- Health centers and district hospitals should be assessed for their capacity to provide forensic evidence collection and/or provide clinical care for GBV survivors in order to increase availability of services.
- CHWs should be trained to provide GBV awareness raising in the community.

SUPERVISION

Three-quarters of health centers and four of nine district hospitals received at least three supervision visits from the district health management team in the quarter prior to the survey. During supervision, the majority of facilities indicated that written comments are provided, feedback/follow-up from the previous visit is provided, and service quality, data quality, and medicines stock are addressed. Staff availability and training are not addressed as often. Almost all (99%) health centers say that they have monthly meetings with CHWs and 72% accompany the CHWs in home visits to check the quality of services provided at least quarterly. During the meetings, they discuss the following points: Follow up to the conclusions of the previous supervisory visit (80%), provide feedback (feedback) on the performance (77%), data verification (76%), tracking data (72%), provide support likely to solve the problems (65%) and observations on service delivery (61%).

Recommendations

- Efforts should be made to ensure that guidelines for conducting supportive supervision are followed consistently.

Annex IV: PMEP Indicators Achievements, Y2

Indicator	Disaggregation	Data Source	Collection Method	Jan-March 2015	April-June 2015	Jul – Sep 2015	Annual 2015	LOP Target
HIV/AIDS Indicators								
Number and percent of pregnant women with known status [NGI]	Known/ new	Facility records	Document review	87.3% (34058/39024)	84.5% (30104/35642)	85.2% (31552/37045)	85.2% (31552/37045)	95%
Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery (DSD)	Prophylaxis type	Facility records	Document review	81.8% (333/407)	91.1% (236/259)	93.6% (308/329)	93.6% (308/329)	95%
Percentage of PEPFAR-supported sites achieving 90% ARV or ART coverage for HIV+ pregnant women		Facility records	Document review	47.9% (56/117)	52.7% (58/110)	61.5% (67/109)	61.5% (67/109)	90%
Percent of infants born to HIV-positive women that receive a virological HIV test within 12 months of birth	Age at test (<2 months or 2-12 months)	Facility records	Document review	0	0	0	0[5]	95%
Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results	Test result, age, sex	Facility records	Document review	121,427	104,961	106,142	332,844	
Number of facilities that provide PEP to GBV survivors	District	Facility records	Document review	26	32	41	41	34 by EoP
Number of health providers trained in GBV case management	District	Training records	Document review	0	0	23	23	(136 by EoP)
Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)	Age, type of care	Facility records	Document review	61	62	77	200	+20%
Percent of key populations reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards	Key population	Facility records	Document review	100% (330/330)	51.5% (170/330)	81.3% (275/330)	78.2% (258/330)	900
Family Planning and HIV Integration: Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services		Facility records	Document review	88.4% (153/173)	88.4% (153/173)	88.4% (153/173)	88.4% (153/173)	90%
Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load	Age, sex	Facility records	Document review	13,219	13,346	13,077	13,077	19866
Percent of HIV-positive positive patients who were screened for TB in HIV care or treatment setting [NGI C2.4.D]	Age, sex	Facility records	Document review	31.7% (4195/13219)	38.4% (5126/13346)	42.1% (5498/13077)	42.1% (5498/13077)	95%
Number of adults and children receiving ART (TA only)	Age, sex	Facility records	Document review	6,397	6,524	6,595	6,595	
Number of PEPFAR-supported testing facilities with capacity to perform clinical laboratory tests (clinical laboratory)				7	7	7	7	6

[5] The Elisa channel used for virological HIV test (PCR) was out of duty throughout the reporting period

Indicator	Disaggregation	Data Source	Collection Method	Jan-March 2015	April-June 2015	Jul – Sep 2015	Annual 2015	LOP Target
Malaria Indicators								
Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women)	District, case type	Facility records Document review	malaria cases treated	24,201	24,739	12,514	61,454	
			malaria cases referred	12,114	8,713	4,069	24,896	
Number of health providers (nurses and medical doctors) trained on the new malaria treatment protocol	District, type of worker, gender	Special study, post-training assessment	**assessment, document review**	48	18	20	86	
Number of CHWs trained in Community case management (CCM) of malaria	District, type of worker, gender	Special study, post-training assessment	**assessment, document review**	70	0	0	70	
Proportion of children under five with fever who received ACT within 24 hours of onset of fever	District, type of worker, gender	Special study, post-training , activity report, assessment	assessment, document review	65.7% (24201/36808)	74.7% (24739/33108)	72.4% (12514/17290)	70.5% (61,454/87,206)	
Number of health communication materials developed, field tested, and disseminated for use	District, type of material	Material, project reports	Document review	0	0	1[6]	1	4
MNCH Indicators								
Proportion of pregnant women attending ANC who received ITNs	Age	Facility records	Document review	81.1% (31702/39079)	77.7% (27381/35261)	81.0% (20303/25056)	79.9% (79386/99396)	
Number/percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs [3.1.6-64]	District, age	Facility records	Document review	3,407	4,566	5,212	13,185	
Number/percent of USG-supported facilities[7] that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC)		Facility records	Document review	46/173	46/173	46/173	46/173	
Number/percent of children who received DPT3 by 12 months of age in USG-Assisted programs [3.1.6-61]	District, sex	Facility records	Document review	23,081	23,661	18,358[8]	65,100	
Proportion of children under five who received ITNs during measles immunization	Gender	Facility records	Document review	94.8% (25469/26879)	91.7% (20721/22594)	98.0% (14793/15098)	94.4% (60983/64571)	
Number/percent of women reached with education on exclusive breastfeeding		Facility records	Document review	16,213	29,546	19,601	65,360	
Family Planning indicators								
Percent of USG-assisted service delivery sites providing family planning counseling and/or services [3.1.7.1-3]		Facility records	Document review	87.9% (152/173)	87.9% (152/173)	88.4% (153/173)	88.4% (153/173)	+5%

[6] Liflet on IPTp

[7] 176 is the total number of facilities in the four IHPB intervention provinces

[8] Routine HIS data for September is not included as it was not yet available at reporting deadline.

Indicator	Disaggregation	Data Source	Collection Method	Jan-March 2015	April-June 2015	Jul – Sep 2015	Annual 2015	LOP Target
Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive methods that the SDP is expected to provide [3.1.7.1-2]		LMIS	Document review	0%	0%	0%	0%	N/A
Health Systems Strengthening indicators								
Number of people trained in supply chain management	District	Project training records	Document reviewer	0	121	238	359	100
Percent of facilities that maintain timely reporting	District, province	District records, HMIS	Document review	173 (100%)	173 (100%)	173 (100%)	173 (100%)	+5%